Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2015	2015_256517_0003	001104-15	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

THE ROYAL OAK LONG TERM CARE CENTRE
1750 Division Road North KINGSVILLE ON N9Y 4G7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 28, 2015

CIS 2939-000002-15 was also reviewed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutritional Manager, the Registered Dietitian, the Program Manager, one Registered Nurse, three Registered Practical Nurses, six Personal Support Workers and one resident. The inspector reviewed the home's policies procedures and education records for mechanical devices used for transfers, education records for pain management, the home's staffing plan, procedures for addressing and documenting resident and family complaints, food menus as well as procedures for the development of the menus.

The following Inspection Protocols were used during this inspection:
Food Quality
Hospitalization and Change in Condition
Pain
Personal Support Services
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents as evidenced by:

Heath record review for resident #001 revealed the resident reported hearing a cracking sound and feeling pain following a transfer using a lift. Interview with the Director of Care revealed Personal Support Workers did not use a safe transferring technique when transferring resident #001 during this transfer. The Director of Care reported that one staff member initiated the transfer without a second staff member present. Review of the unit's 24 hour report sheet revealed a Personal Support Worker reported to a Registered Staff member resident #001 required a different lift for transfers following this transfer.

Review of the unit's 24 hour report sheet also revealed one Personal Support Worker reported resident #001 had difficulty with a transfer two days earlier and required further assessment for the ability to use this particular lift safely. Following this, the resident was not reassessed for the ability to use the lift safely and continued to use the same lift daily for all transfers.

The home's policy titled: "Mechanical Lifts and Resident Transfers" Policy # LTC-CA-WQ-200-07-13 November 2014 version stated:
"Two staff are required at all times when a mechanical device is used to transfer and/or lift a resident."
The Administrator and the Director of Care verified two staff were required at all times when a mechanical device was used to transfer and or lift a resident. [s. 36.]

Interview with six Personal Support Workers, three Registered Practical Nurses and one Registered Nurse revealed the expectation was that two Personal Support Workers were present at all times when a mechanical lift was used to transfer a resident. The staff further reported that when a resident experienced difficulty with a transfer using a mechanical lift, the expectation was that a staff member assess the resident's ability to transfer with the mechanical lift during the resident's next transfer to ensure resident safety. This was confirmed by the Director of Care.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 20th day of February, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.