Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: 2023-03-22	
Inspection Number: 2023-1265-0003	
Inspection Type: Critical Incident System	
Licensee: The Central Canadian District of the Christian and Missionary Alliance in Canada	
Long Term Care Home and City: CAMA Woodlands Nursing Home, Burlington	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2023.03.27 10:34:04 -04'00'
Additional Inspector(s) Farah Khan (695) was present during this inspection	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 9, 10, 13, and 15, 2023

The following intake was inspected:

- Intake: #00002690 - Resident sustained injury during transfer with lift

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC # remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 s. 138 (1) (a) (ii)

Description of Noncompliance
A medication cart was left idle in the hallway and it was unlocked, with the tablet screen on displaying a resident's information.

After a discussion with the Long-Term Care Inspector, the RPN locked the cart and the tablet screen right away. No residents were in proximity.

Sources

Staff Observation, Interview with RPN and DOC, Policy # 7.1 Drug storage "Revised May 2022".

[741771]

Date Remedy Implemented: March 9, 2023

WRITTEN NOTIFICATION: Transferring Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when transferring a resident, resulting in the resident being injured.

Rationale and Summary

A resident required a Hoyer lift, and two persons assist for transfer. One PSW was to control the lift and the second PSW was to be the spotter (supporting and making sure the resident was safe during the transfer).

The home's policy # 05-06-07 - Resident Care Manual on Transfers, "Revised September 2017 outlines that; an appropriate transfer is one that ensures the safest and most comfortable procedure for the resident and the caregiver. Caregiver must complete the following task to prepare for a resident transfer: Confirm that the prescribed transfer is still the most appropriate technique for the resident by completing a CARE assessment. By ensuring that the environment is ready, ensuring that the path of transfer is clear by removing any obstacles, ensuring furniture is arranged to allow easy access, ensuring that the environment is prepared, and equipment is positioned and used correctly.

Two PSWs were transferring a resident via Hoyer lift from their wheelchair to their bed. The PSWs failed to conduct a safety assessment prior to the beginning of their transfer.

One of the PSWs acknowledged that they should have assessed the resident's environment and made sure they had enough space prior to attempting to transfer the resident on the lift.

The DOC confirmed that staff did not follow the safety precaution prior to the transfer and should have ensured that they had enough room to maneuver prior to attempting to transfer the resident.

The home not ensuring that a safety precaution was taken during a transfer moderately impacted the resident and resulted in the resident being injured.

Sources
Record review of the resident, Interview with the PSW and DOC, Policy # 05-06-07

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