Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2020	2020_569508_0008	018035-19	Critical Incident System

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court BURLINGTON ON L7N 3N6

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

Crescent Park Lodge
4 Hagey Avenue Fort Erie ON L2A 5M5

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15, 16, 17 and 20, 2020.

A complaint inspection #2020_569508_0007 was conducted concurrently during this Critical Incident (CI) inspection.

During this inspection, the inspector toured the facility, observed the provision of care, reviewed investigative notes, resident clinical records, relevant policies and procedures and training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	Légende 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 techniques when assisting resident #004.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care where an incident occurred on an identified date in 2019, that caused injury to resident #004 for which the resident was taken to hospital.

A review of the CI report indicated that resident #004 was was being transferred via mechanical lift with two (2) PSW staff present. The report indicated that there was an issue with the equipment during the transfer and the resident fell backward and struck their head on the floor. The resident sustained an injury, was transferred to hospital for further assessment and returned to the home.

During review of the home's internal investigative notes, it was identified that initially the PSW's, (PSW #105 and #106) demonstrated to the Administrator with the mechanical lift how the incident occurred. The home contacted their representative from the mechanical lift company to conduct an inspection of all their lift equipment. The representative came in and determined the equipment used in the incident was not in disrepair.

The following day, PSW #106 reported to management that they had not been truthful during the investigation and that they were not present with PSW #105 during the transfer. PSW #105 who was responsible for the resident's care and who was operating the lift was then questioned again regarding the incident. PSW #105 then admitted to performing the lift and transfer of this resident by themselves.

The DOC confirmed on January 16, 2020, that all mechanical lifts in the home require two staff when transferring residents for safety and that PSW #105 did not use safe transferring techniques when assisting resident #004. [s. 36.]

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 the staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 14th day of February, 2020

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

Original report signed by the inspector.