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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
May 21, 2020	2020_786744_0009	023216-19	Critical Incident System

Licensee/Titulaire de permis

Foyer Hearst - Mattice - Soins De Sante
67-15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

Foyer Des Pionniers
67 15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

STEVEN NACCARATO (744)

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): March 9-11, 2020

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
-One intake regarding a fall of a resident resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Health Care Aides (HCAs) and residents.

The Inspector also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

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 :

A critical incident (CI) report was submitted to the Director, related to resident #001 sustaining an injury.

Inspector #744 reviewed the home's internal investigation notes, which included a note, indicating that Health Care Aide (HCA) #106 stated that they positioned resident #001 on a piece of equipment, which led to an injury of the resident. HCA #106 further stated that the required safety device for the piece of equipment was not applied to the resident at the time of the incident.

Inspector #744 reviewed the manufacturer's instructions for the specific piece of equipment used by resident #001, which specified the correct positioning of the patient and safety device required while utilizing the specific piece of equipment.
In an interview with Inspector #744, HCA #100 and #101, Registered Practical Nurse (RPN) #102 and Registered Nurse (RN) #103 indicated that the safety device for the specific equipment must always be applied.

Inspector #744 interviewed the Director of Care (DOC); they indicated that in order to prevent injury and maintain resident safety, the safety device must always be applied to the residents when using the specific equipment. They verified that HCA #106 should have had the safety device applied to resident #001.
[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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 21st day of May, 2020

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

Original report signed by the inspector.