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
Dec 2, 2021	2021_729615_0032	016293-21	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Huron
1 Courthouse Square Goderich ON N7A 1M2

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

Huronlea Home for the Aged
820 Turnberry Street South Brussels ON N0G 1H0

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

HELENE DESABRAIS (615)

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): November 22, 23 and 24, 2021.

The following intake was inspected during this inspection:

Log #016293-21/CIS related to improper care of a resident that resulted in harm.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Services Manager - Infection Prevention and Control (ESM-IPAC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), a Personal Support Worker (PSW), two housekeepers and the Screener Staff.

The inspector also toured the home, observed Infection Prevention and Control practices, residents and the care provided to them, reviewed residents' clinical records, the home's policies and procedures and other relevant documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 has failed to ensure that staff used safe techniques when transferring a resident.

At the time of the incident, a staff activated the call bell to have a second staff assist them with the transfer of a resident. While waiting for assistance, the staff unfastened the resident's device. The resident slipped out of the device fell on the floor. As a result of the fall, the resident's sustained injuries.

The staff did not use safe transfer techniques as outlined in the home's Handle With Care Mechanical Lift Transfer Policy, which states that when performing transfers there must be two people present. The Administrator said the staff member was trained on safe transfer techniques but did not use them when transferring the resident.

Sources: LTCH's Critical Incident Report and investigation notes, Handle with Care Mechanical Lift Transfer Policy (last reviewed on January 2020), a resident's clinical records, and interviews with the Administrator and other staff. [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 techniques when assisting resdients, to be implemented voluntarily.

Issued on this 3rd day of December, 2021

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

Original report signed by the inspector.