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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 31, 2018	2018_539120_0022	009474-18	Critical Incident System

Licensee/Titulaire de permis

Maryban Holdings Ltd.
3700 Billings Court BURLINGTON ON L7N 3N6

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

Oakwood Park Lodge
6747 Oakwood Drive NIAGARA FALLS ON L2E 6S5

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

BERNADETTE SUSNIK (120)

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): May 16, 2018

A critical incident (2661-000021-18) report was submitted by the licensee related to an injury sustained by a resident while being transferred by staff members using transfer equipment.

During the course of the inspection, the inspector(s) spoke with the Administrator and personal support workers (PSWs).

During the course of the inspection, the inspector reviewed the resident's clinical records, staff attendance for transfer training, preventive maintenance records for the transfer equipment in the home, observed transfer equipment and accessories in one section of the home and observed two personal support workers using transfer equipment.

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	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 has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

According to interviews with two personal support workers (PSWs) during the inspection, resident #100 was transferred from one surface to another using transfer equipment and an accompanying accessory in May 2018. Both PSWs were required to ensure that the resident was properly positioned and transferred using the appropriate transfer equipment and accessories for the resident's condition.

The resident was transferred from one area of the home to another, requiring both PSWs to manage the equipment. When the equipment was stopped at the desired destination, the resident fell from the transfer equipment and sustained an injury. Neither of the PSWs could explain how the resident fell from the transfer equipment, but suspected the resident shifted their position. According to a third PSW, who witnessed the incident, the transfer equipment accessory did not appear to have been attached to the transfer equipment.

According to the resident's clinical records, the resident was transferred to hospital on the same date as the incident and returned by end of day with a confirmed injury.

According to records from the transfer equipment manufacturer, the equipment and accompanying accessory were both inspected on the date of the incident. No malfunction of the equipment or accessory was identified. The cause of the fall was deemed to have been operator error.

During the inspection, a re-enactment of the incident with the assistance of two PSWs from the Safe Handling Committee was conducted. During the re-enactment, the results that PSWs #001 and #002 reported could not be replicated.

Although the exact reason why the resident fell from the transfer equipment and accompanying accessory were inconclusive, the resident fell from the equipment during a transfer process and became injured while being supervised by two PSWs. [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 4th day of June, 2018

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

Original report signed by the inspector.