Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| May 30, Jun 1, 4, 5, 2012 | 2012_054133_0022 | Critical Incident |

**Licensee/Titulaire de permis**

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St, CORNWALL, ON, K6J-5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET, CORNWALL, ON, K6J-5T2

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

JESSICA LAPENSEE (133)

## Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Personal Support Workers and a resident.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report, observed the tub chair in use in a tub room room in a Resident Home area , reviewed the manufacturer instructions for use of this tub chair and reviewed components of a residents' health care record.

The on site inspection occurred on May 30th, 2012.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.**

**Findings/Faits saillants :**

1. After being bathed on April 11, 2012, resident #1 slid off a tub chair in a tub room in a Resident Home Area while Personal Support Worker (PSW) #S100 was drying the residents' feet. On April 13, 2012, resident #1 was transferred to the hospital for further assessment and treatment of the injury that was sustained as a result of the fall.

The tub chair is manufactured by Penner Manufacturing Inc and is referred to as the "Transfer Electric Pacific Chair" (model #393000-1). Written instructions for use of the tub chair are found in the document titled "Patient Chair Transfer/Lift System, Safe Operating & Daily Maintenance Instructions" (394750 Revision A 08/02/05) and were reviewed by the inspector. In this document, the equipment user is guided in how to apply the seat belt once the resident is seated in the tub chair and warned that failure to secure the resident properly with the seat belt could result in injury to the resident or operator. It was also noted during the inspection that there are written instructions to staff affixed to the wall in the Resident Home Area tub room which summarize the manufacturer instructions on how to apply the tub chair seat belt and states that all residents are to be wearing the seat belt while seated in the tub chair.

PSW #S100 who provided the bath did not apply the tub chair seat belt to resident #1 while he/she was seated in the tub chair. This equipment was not used in accordance with manufacturer's instructions.

***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 with the requirement that all staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.***

**Issued on this 8th day of June, 2012**

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

Jessica Lapensée