Ontario

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

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


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

| Date(s) of inspection/Date de l'inspection | Inspection No/ d'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| November 8 and 9, 2010 | 2010_147_2881_08Nov104349<br>2010_147_2881_08Nov111753 | Critical Incident – H-01527 and H-01801 |

**Licensee/Titulaire**
Oakwood Retirement Communities Inc.
325 Max Becker Drive
Suite 201
Kitchener, ON
N2E 4H5

**Long-Term Care Home/Foyer de soins de longue durée**
The Village of Erin Meadows
2930 Erin Centre Boulevard
Mississauga, Ontario
L5M 7M4

**Name of Inspector**

Laleh Newell - #147

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to injuries sustained as a result of improper transfer by staff.

During the course of the inspection, the inspector spoke with:

Director of Care, Assistant Director of Care, RAI Coordinator, Administrator, staff and resident.

During the course of the inspection, the inspector:

Reviewed health care records, reviewed policy and procedures related to safe transfers and lifts, reviewed personnel file of staff member involved in the incident, reviewed internal incident report and home's investigation report related to the incident, toured the home, and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

Fall Prevention

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[1] WN
[1]VPC

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

| | |
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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**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.

**Findings:**

1. An identified resident was assessed in January 2010 to require a two person assist utilizing a sit to stand lift while being transferred for toileting and to have constant supervision. However in September 2010, resident was transferred by one staff for toileting and the staff member left the resident unattended to get additional supplies, upon return of the staff member, the resident was found on the floor in the bathroom. The resident was assessed and transferred to an acute hospital for further

assessment and treatment for injuries.

2. An identified resident was assessed in May 2009 to require a two person assist utilizing a sit to stand lift while being transferred for toileting. However in September 2010, resident was transferred manually by one staff member for toileting, subsequently the resident fell and sustained an injury.

| **Inspector ID #:** | 147 |
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**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 all staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

| **Signature of Licensee or Representative of Licensee**<br>**Signature du Titulaire du représentant désigné** | **Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**<br>Dec 3/10. |
|---|---|
| **Title:** **Date:** | **Date of Report:** (if different from date(s) of inspection). |