Ontario

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2013	2013_201167_0010	H-000040-13, H-000032-13	Critical Incident System

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8, STONEY CREEK, ON, L8G-1G6

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

ARBOUR CREEK LONG-TERM CARE CENTRE
2717 KING STREET EAST, HAMILTON, ON, L8G-1J3

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 2, 3, 2013

This inspection was completed related to critical incidents (H-000032-13 & H-000040-13) and was conducted simultaneously with the Resident Quality Inspection (RQI) at the home.
A finding of non-compliance O. Reg. s. 30(2) was issued on the RQI report related to critical incident inspection H-000040-13.

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered staff and personal support worker staff (PSWs), two identified residents and recreation staff.

During the course of the inspection, the inspector(s) observed care, conducted a review of the health files for two identified residents, reviewed relevant policies and procedures, reviewed the home's investigation notes into two critical incidents and reviewed relevant education provided to staff.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. A resident at the home was not transferred using safe transferring technique.

A) Resident # 915 was noted to have sustained an injury in 2012.
B) The mobility assessment completed in 2012 for the resident indicated that the resident could not fully weight bear and required the use of a full mechanical lift for all transfers.
C) The document that the home refers to as the care plan for the resident directed staff to provide the resident with total assistance of two staff and use of a full sling mechanical lift for transfers.
D) The home's policy and procedure related to transferring with a mechanical lift (RC-05-06-06B) dated January 13, 2009 directed staff to use two persons to assist with transfers with a mechanical lift.
E) The home conducted an investigation into how the injury may have occurred and it was confirmed that a staff member transferred the resident using a mechanical lift without the assistance of another staff member the evening prior to the injury being discovered. [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 devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 27th day of May, 2013

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

Marilyn Lore