Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: December 19, 2024

Inspection Number: 2024-1194-0005

Inspection Type:
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Blenheim Community Village, Blenheim

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 9, 13, 16, 18, 2024
The inspection occurred offsite on the following date(s): December 12, 17, 2024
The following intake(s) were inspected:
• Intake: #00128699 [Critical Incident (CI): 2695-000018-24] - related to Skin & Wound Prevention and Management
• Intake: #00131337 [CI: 2695-000022-24] - related to Resident Care and Support Services
• Intake: #00132094 [CI: 2695-000026-24] - related to Skin & Wound Prevention and Management
• Intake: #00132238 [CI: 2695-000027-24] - related to Prevention of Abuse and Neglect

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary

A review of the home's internal investigation notes revealed that a staff member admitted to forgetting the device attached to the resident during the transfer. A management team member stated the importance of monitoring the resident while providing care. Both staff members stated that to prevent the incident from reoccurring, they should have consulted with the registered staff prior to transferring resident.

A management team member confirmed that the device became caught and compromised during the resident's transfer. Both the staff member involved and another management team member explained that the expectation was for staff to maintain the device's integrity while ensuring a safe transfer.

Failure to use safe transferring and positioning techniques placed the resident at risk of injury.

Sources: Internal investigation notes and interviews with staff and management team members.