Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2021	2021_927957_0005	012442-21, 012676-21, 013590-21, 013846-21, 016066-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 3) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Chelsey Park
310 Oxford Street West London ON N6H 4N6

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

CATHERINE OCHNIK (704957), CHRISTINA LEGOUFFE (730)

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): November 17, 18 and 22, 2021.

The following intakes were completed in this Critical Incident Inspection:

Related to falls prevention:
Critical Incident Log# 012442-21/ CI 2655-000018-21
Critical Incident Log# 013846-21/ CI 2655-000022-21
Critical Incident Log# 016066-21/ CI 2655-000025-21

Related to responsive behaviors:
Critical Incident Log# 013590-21 /CI 2655-000021-21

Related to improper transfer technique:
Critical Incident Log# 012676-21 /CI 2655-000019-21

During the course of the inspection the inspectors toured the home, observed residents and the care provided to them, observed resident rooms and common areas, reviewed health care records, plans of care for identified residents, relevant home policies and procedures and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC) and Assistant Director of Care (ADOC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	Légende 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 techniques when assisting a resident.

Staff members were assisting a resident and failed to use safe transferring techniques which resulted in the resident sustaining an injury.

In an interview, a PSW indicated that they did not use the proper transferring technique while transferring the resident, and this caused an injury to the resident.

The home’s training materials related to transferring residents included direction to staff on proper transferring techniques.

As a result of the improper transfer there was actual harm to a resident, as they sustained an injury and were transferred to hospital.

Sources: Resident progress notes, interviews with PSW and RN, the home's training materials. [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 techniques when assisting a resident, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 26th day of November, 2021

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

Original report signed by the inspector.