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

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
Telephone: 1-800-663-6965
SudburySAO.moh@ontario.ca

Original Public Report

Report Issue Date July 27, 2022
Inspection Number 2022_1351_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
CVH (No. 9) 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.)

Long-Term Care Home and City
Southbridge Roseview, Thunder Bay.

Lead Inspector
Steven Naccarato (ID#744)

Additional Inspector(s)
Jennifer Nicholls (ID#691)
Christopher Amonson (ID#721027)

Inspector Digital Signature
Steven C Naccarato
Digitally signed by Steven C Naccarato
Date: 2022.07.28 15:14:52 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 11-15, 2022. Off-site inspection activities occurred on July 21, 2022.

The following intake(s) were inspected:

- Three intakes related to resident care concerns;
- One intake related to an improper transfer of a resident; and,
- One intake related to improper treatment of a resident.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Skin and Wound Prevention and Management

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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. 79/10 *s. 36.*

The licensee has failed to ensure that a PSW (Personal Support Worker) used safe transferring techniques while transferring a resident using a mechanical lift.

Rationale and Summary
A PSW transferred a resident using a Mechanical lift without assistance from a second staff member. In an interview with the Executive Director (ED), they stated that two people were required when performing a Mechanical Lift according to policy; one staff member to operate the Mechanical Lift and one staff member to ensure resident safety.

There was minimal harm to the resident caused by the unsafe transfer.

Sources: The CIS (Critical Incident System) report; the home's investigation notes; the home's policy titled "Mechanical Lifts" last updated August 2017; interview with the ED and other staff.

[744]