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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 6, 2019	2019_633577_0016	008449-19, 009726-19	Critical Incident System

Licensee/Titulaire de permis

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.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Lakehead
135 South Vickers Street THUNDER BAY ON P7E 1J2

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

DEBBIE WARPULA (577)

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): July 16, 17 and 18, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- Two intakes related to improper use of mechanical lifts.

A Follow up inspection #2019_633577_0017 was conducted concurrently with this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Personal Support Workers (PSWs), and one resident.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed employee files and investigation records, reviewed staff training records, reviewed relevant health care records, as well as reviewed a licensee policy and program.

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

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 and positioning devices or techniques when assisting resident #001 and #002.

A Critical Incident System (CIS) report was received by the Director concerning an

unsafe transfer of resident #001. The CIS report indicated that PSW #102 had operated a specific device without the assistance of a second staff member.

A second Critical Incident System (CIS) report was received by the Director concerning an unsafe transfer of resident #002. The CIS report indicated that PSW #101 had operated a specific device without the assistance of a second staff member.

a) A review of resident #001's care plan in place at the time of the incident, included an intervention initiated on an identified date, which indicated that staff were to have used a specific device for the resident's specific care activity with the assistance of two staff.

The home's investigation notes related to the incident, included an interview on an identified date, between the home and PSW #102; wherein, PSW #102 had confirmed that they had used the specific device without assistance while transferring resident #001 during a specific care activity. A written statement from Housekeeping aide #103, on an identified date indicated that they witnessed PSW #102 to have transferred resident #001 unassisted during a specific care activity with a specific device. In addition, there was a letter from the home to PSW #102 on an identified date, which indicated that they received a written warning letter for violation of the "Safe Lifting with Care RC-08-01-11" policy by assisting a resident with a specific care activity using a specific device alone.

During an interview with PSW #102, they stated to Inspector #577 that when they had transferred resident #001 during a specific care activity, their co-worker stood at the doorway of the tub room and witnessed them transfer the resident during a specific care activity. They confirmed that two staff were required when operating specific devices.

b) A review of resident #002's care plan in place at the time of the incident, included an intervention initiated on an identified date, which indicated that the resident required specified assistance with a specific device with the assistance of two staff.

A review of resident #002's particular assessment in place during time of the incident, indicated that the resident required a specific device for specific care activities.

The home's investigation notes related to the incident, included an interview on an identified date, between the home and PSW #101; wherein, PSW #101 had confirmed that they had used a specific device without assistance while transferring resident #002 during a specific care activity. They stated that they had misunderstood using the specific device unassisted when their co-worker PSW #104 told them to complete the care for the

resident before they went on a break. In addition, there was letter from the home to PSW #101 on an identified date, which indicated that they received a written warning letter for violation of the "Safe Lifting with Care RC-08-01-11" policy by assisting a resident during a specific care activity using a specific device alone.

During an interview with PSW #101, they stated to Inspector #577 that they had misunderstood PSW #104, and used a specific device to transfer resident #002 during a specific care activity unassisted. They further confirmed that two staff were required when using specific devices.

During an interview with PSW #104, they reported to Inspector #577 that they were working with PSW #101 on an identified date. They stated they had asked PSW #101 whether they had used a specific device unassisted, as the resident was up in their chair dressed for the day. They reported that PSW #101 had admitted to have used the specific device and they instructed them that the specific device could not be used without assistance of two staff.

A review of the home's policy, "Safe Lifting with Care Program - LP-01-01-01", revised August 2017, indicated that two trained staff were required at all times when performing a mechanical lift; when the resident assessment indicated that a mechanical lift was required, staff would follow the established procedure and use approved mechanical lifting equipment. A mechanical lift included a floor model lift, a ceiling lift, a sit-to-stand lift and a tub lift.

During an interview with PSW #105 and PSW #106, they reported to Inspector #577 that two staff were needed for all transfers when they used specific devices.

During an interview with RN #107 they confirmed with the Inspector that two staff had to be present when they connected a resident to a specific device, during the transfer and present until they were disconnected from the specific device.

Together, the Administrator and Inspector#577 reviewed care plan interventions for resident #001 and #002. They confirmed that PSW #101 and PSW #102 were not following the care plan interventions when they transferred resident #001 and #002 with specific devices without assistance and they were not following the home's Safe Lifting with Care Program, as two staff were required to operate specific devices in the home. [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 8th day of August, 2019

[redacted]

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

Original report signed by the inspector.