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

Hamilton District
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Original Public Report

Report Issue Date: September 11, 2023	
Inspection Number: 2023-1339-0003	
Inspection Type: Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Tansley Woods, Burlington	
Lead Inspector Meghan Redfearn (000765)	**Inspector Digital Signature** Meghan Redfearn Digitally signed by Meghan Redfearn Date: 2023.09.19 10:11:40 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28 - September 1, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00085442/CI #2852-000014-23- related to Falls Prevention and Management.

The following intakes were completed in this CI inspection:

- Intake: #00086259/CI #2854-000015-23- related to Falls Prevention and Management.

Training Specialist Basel Mansour was also present during the inspection.

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

Infection Prevention and Control
Falls Prevention and Management

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

The licensee has failed to ensure that staff used safe transferring and positioning devices when assisting a resident after an incident.

Rationale and Summary
On an identified date, a resident had an incident occur which resulted in an injury. Two staff members manually assisted a resident without using a safe transferring device. The home's "Transfer Status Assessment Guide" policy indicated there is no manual assistance in the villages.

During the home's investigation a staff member stated that it was safer to assist the resident manually and that they could assist the resident without the transferring device. An education note instructed staff to always use a transferring device while assisting a resident.

A staff member acknowledged that the home had a transfer policy and that a transferring device should be used to assist residents who experience an incident. They also acknowledged that manual assistance is not allowed because it could cause more harm to the resident and that they should not have assisted the resident without the transferring device.

Failure to ensure that staff used safe transferring and positioning devices during the transfer put a resident at a safety risk.

Sources: critical incident report; the home's investigation notes; the home's "Transfer Status Assessment Guide" policy; interview with a staff member.

[000765]