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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Original Public Report

Report Issue Date: July 16, 2024
Inspection Number: 2024-1448-0002
Inspection Type: Critical Incident Follow up
Licensee: The Women's Christian Association of London
Long Term Care Home and City: McCormick Home, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, 12, 2024

The following intake(s) were inspected:

- Intake: #00114701, Follow-up for CO #001 from 2024-1448-0001, related to medication management system.
- Intake: #00115496, Critical Incident related to improper/incompetent care of a resident.
- Intake: #00117145, Critical Incident related to a resident's fall.
- Intake: #00118494, Critical Incident related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1448-0001 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Ali Nasser (523)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Transfers

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 members used safe and proper techniques when transferring a resident.

Rationale & Summary:
A critical incident (CI) was submitted to the Director related to improper transferring techniques that resulted in a resident injury.
The home's investigation note noted that the PSWs had failed to properly and safely complete the resident's transfer.

The Director of Care (DOC) confirmed that an investigation was conducted by the home and determined there was an unsafe transfer that resulted in resident's injury. DOC stated that during the investigation both PSWs acknowledged their failure to use proper and safe transferring techniques. DOC also informed that the home had

added an additional component to the home's mechanical lift transfers, and transfer device audit tool to make sure that the staff were engaging in proper communication with each other during the process.

PSW's failure to use proper and safe transferring techniques put the resident at the risk of fall and injury.

Sources: record reviews and staff interviews. [000830]