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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: January 10, 2025

Inspection Number: 2024-1091-0005

Inspection Type:
Critical Incident

Licensee: CVH (No. 5) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Country Village Homes - Woodslee, South Woodslee

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 8, 9, 10, 2025

The following intake(s) were inspected:

- Intake: #00131434 - IL-0133331-AH/2576-000047-24 - related to resident care.
- Intake: #00132207 - IL-0133622-AH/2576-000048-24 - related to alleged resident to resident abuse
- Intake: #00135490 - IL-0135090-AH/2576-000050-24 - related to the fall of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Unclear Care Plan Direction

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that written directions in the plan of care for a resident provided clear direction as to when one gait aid was to be used opposed to another. There was risk of the resident falling when staff were not provided clear direction surrounding the resident's locomotion.

Sources: care plan, interviews, and physiotherapy progress notes.

WRITTEN NOTIFICATION: Unsafe Mechanical Lift Transfer

NC #002 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 failed to ensure that safe transferring techniques were used when a staff member transferred residents with a mechanical lift without the assistance of

an additional trained staff member. The home's policy and training stated that two trained staff members conducted all transfers of residents when utilizing a mechanical lift.

Sources: the licensee's mechanical lift training and interviews.