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

Original Public Report

Report Issue Date: July 22, 2024
Inspection Number: 2024-1009-0003
Inspection Type: Complaint
Licensee: CVH (No. 8) 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: Queensway Long Term Care Home, Hensall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17, 19, 2024

The following intake(s) were inspected:

- Intake: #00114257 - e-Correspondence related to the care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation services

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure a piece of resident equipment was in a good state of repair.

The ministry received a complaint regarding a piece of resident equipment that had lost functionality, which in turn contributed to medical issues for the resident.

The review of the resident's care plan revealed that the equipment should be inspected weekly on the resident's scheduled bath days. Staff at the home were instructed to search for any signs of damage, such as cracks, loose stitching, tears, depressions, holes, and stains.

A review of documentation revealed that the home's staff were not documenting on checking the equipment.

During an interview a staff member stated that they had seen the damage to the equipment but had not reported or documented on it.

The home's Executive Director acknowledged that the expectation would be for the home's staff to document on and to report any damaged equipment.

The home replaced the equipment after becoming aware that it was not meeting the resident’s needs.

Source: Complaint, observation in room, interviews with the home's staff.

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