

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
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
Nov 30, 2021	2021_617148_0024	013685-21, 015274-21	Complaint

Licensee/Titulaire de permis

Osgoode Care Centre
7650 Snake Island Road Metcalfe ON K0A 2P0

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

Osgoode Care Centre
7650 Snake Island Road Metcalfe ON K0A 2P0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 18 and 19, 2021

This inspection included complaint log 015274-21 and log 013685-21, both related to concerns of improper/incompetent treatment of a resident that resulted in harm.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Worker Coordinator, and Personal Support Workers (PSW).

The Inspector reviewed the resident's health care record and document pertaining to the licensee's investigation into the incident. The resident's care and environment were observed.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 failed to ensure that a PSW used safe transferring techniques when assisting a resident.

A PSW used a mechanical lift to transfer a resident, without a second person assist.

In performing a one person mechanical lift, the resident was placed at risk for injury.

Sources: Interview with the PSW Coordinator and review of the resident's health care record and licensee's investigation. [s. 36.]

Issued on this 1st day of December, 2021

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

Original report signed by the inspector.