

**Ministry of Long-Term Care**

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

**Central East District**

33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

## Original Public Report

**Report Issue Date:** November 13, 2024

**Inspection Number:** 2024-1354-0004

**Inspection Type:**

Critical Incident

**Licensee:** Axiom Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axiom Extendicare LTC II GP Inc.

**Long Term Care Home and City:** Elginwood, Richmond Hill

**Lead Inspector**

**Inspector Digital Signature**

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2024, and November 4, 2024.

The following intake(s) were inspected:

- An intake related to prevention of abuse and neglect.
- An intake related to resident care and support services.

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

Resident Care and Support Services  
Infection Prevention and Control  
Prevention of Abuse and Neglect

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Reporting and Complaints

## 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**

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 license has failed to ensure staff used safe transferring techniques when assisting resident #002.

#### Rationale and Summary

The Director received a Critical Incident Report (CIR) related to allegation of physical abuse to resident #002 related to a significant injury due to unknown cause.

Upon staff interviews and review of the home's investigation notes, Personal Support Worker (PSW) #112 confirmed that prior to the resident's identified injury, they used to transfer the resident via a mechanical lifting device with presence of the resident's caregiver and not a trained member of the home.

The home's policy titled "Safe Resident Handling" indicated two home's staff must be always present while the mechanical lifting and transferring devices are in

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operation, moreover the staff must have received Safe Ambulation, Lift, and Transfers (S.A.L.T) in-services and training.

PSWs #109 and #111 both confirmed that caregivers were not to be considered a trained member of the home with regards to safe transferring the residents using mechanical lifting devices.

The Director of Care (DOC) acknowledged the same and indicated that transfers involving mechanical lifting devices must be always performed by two staff members of the home who received the appropriate trainings including S.A.L.T.

Failure to transfer resident #002, using a mechanical lifting device with presence of their caregiver as a second person, put the resident at risk of harm as it was an unsafe transferring technique.

**Sources:** The CIR, the home's investigation notes, the home's policy titled "Safe Resident Handling", Procedure descriptions titled "Operation of Mechanical Lifting/Transferring and Repositioning Devices" and "Team Roles and Responsibilities", and multiple staff interviews.