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

Central West District
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 19, 2023	
Inspection Number: 2023-1628-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the City of Guelph	
Long Term Care Home and City: The Elliott Long Term Care Residence, Guelph	
Lead Inspector Megan Brodhagen (000738)	**Inspector Digital Signature** Megan Brodhagen Digitally signed by Megan Brodhagen Date: 2023.09.20 10:32:43 -04'00'
Additional Inspector(s) Jessica Bertrand (722374) was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 7-8, 2023 and September 11-13, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00086730 was related to falls prevention and management.
- Intake #00094666 was related to outbreak management.

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

Infection Prevention and Control
Falls Prevention and Management

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

The licensee has failed to ensure that staff members used safe transferring and positioning devices or techniques when assisting a resident after a fall.

Rationale and Summary
A resident fell. A Registered Nurse (RN) and a Personal Support Worker (PSW) transferred the resident by carrying them back to bed as they were not able to weight-bear.

The home's "Fall Prevention & Management Program Policy" directed Registered Nursing staff to move residents after a fall with a 2-person mechanical lift if the resident was unable to weight-bear. A RN said staff were to use a mechanical lift to transfer a resident post-fall if that resident could not weight-bear.

The resident was placed at risk of harm when they were improperly transferred post-fall.

Sources: Fall Prevention & Management Program Policy, Resident's clinical records, and Interviews with staff.

[000738]