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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 23, 2023	
Inspection Number: 2023-1082-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Elm Grove Living Centre Inc.	
Long Term Care Home and City: Elm Grove Living Centre, Toronto	
Lead Inspector Adelfa Robles (723)	**Inspector Digital Signature**
Additional Inspector(s) Cindy Ma (000711)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16 – 19, 2023

The following intake(s) were inspected:

- Intake: #00018241 – [Critical Incident (CI): 2515-000002-23] – related to fall with injury
- Intake: #00084056 – related to a complaint due to improper transfer

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

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services

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 use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A resident's clinical records indicated that they fell because a staff used a wrong device to transfer a resident.

Staff stated that the resident fell because the assigned staff used the wrong device during transfer. Another staff stated that the incident could have been prevented if the appropriate device was used. The home confirmed that the incident was due to improper transfer.

There was an actual harm to a resident when the staff failed to use the appropriate equipment to assist them during transfer.

SOURCES:
A resident's clinical records and staff interviews.

[723]