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: November 23, 2023
Inspection Number: 2023-1055-0005
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare London, London

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.11.23 13:09:06 -05'00'

Additional Inspector(s)
Julie Lampman (522)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 and 21, 2023.

The following intake(s) were inspected:

- Intake: #00093687 CIS #2173-000020-23 related to Resident Care and Support Services
- Intake: #00098727 CIS #2173-000030-23 related to Falls Prevention and Management
- Intake: #00099706 CIS #2173-000032-23 related to Falls Prevention and Management.

The following intake(s) were completed in this inspection:

- Intake: #00093487 CIS #2173-000019-23 related to Falls Prevention and Management
- Intake: #00096408 CIS #2173-000025-23 related to Falls Prevention and Management.

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

Resident Care and Support Services
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 used safe transferring devices when assisting a resident.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted related to a resident who had sustained a fall. There were directions in the resident's care plan to be followed for the resident's safety related to a transfer device. During the home's investigation, it was determined that staff had not followed these directions.

A staff member stated they had thought the resident's transfer status had been changed. The staff member acknowledged they should have checked the resident's care plan to ensure the resident had been reassessed by the physiotherapist and their transfer status had changed to a different device.

Although the resident did not fall due to the use of the device, there was a risk to the resident when staff had not used a transferring device as per care plan when assisting the resident.

Sources: CIS report, a resident's clinical record, the home's "Safe Lifting with Care Program" LP-01-01-01 last updated July 2022, and interviews with staff members, Director of Care (DOC) #101 and DOC #102. [522]