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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 26, 2022
Inspection Number 2022_1093_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Medex, Ottawa

Lead Inspector
Susan Lui (178)

Additional Inspector(s)
Lisa Cummings (756)

Inspector Digital Signature
Susan Lui
Digitally signed by Susan Lui
Date: 2022.09.06 13:19:36 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 7-8, 12-15, 18-22, 25, 2022.

The following intake(s) were inspected:

- Intake #020140-21 (CIS #2579-000024-21) related to an improper transfer
- Intake #010044-22 (CIS #2579-000009-22) and Intake #016548-21 (CIS #2579-000020-21) related to falls that caused injury and required a transfer to hospital
- Intake #018055-21 (Complaint) related to an allegation of emotional abuse, resident's bill of rights, and the communication response system

The following intakes were completed during this inspection: Intake #009811-22 (CIS #2579-000008-22) and Intake #020856-21 (CIS #2579-000025-21) related to falls.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION [TRANSFERING AND POSITIONING TECHNIQUES]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 36

The licensee has failed to ensure that safe transferring techniques were used when assisting a resident.

Rationale and Summary

A resident was assisted by two Personal Support Workers (PSW) with a transfer using a mechanical lift. A PSW stated they assisted with the transfer and the sling became unhooked causing the resident to fall and sustain an injury.

An Assistant Director of Care (ADOC) stated the licensee's investigation found that the supports for the sling were not in place as required for this transfer and this contributed to the fall.

As a result, the resident sustained an injury and required a transfer to hospital.

Sources: Progress notes and interviews with an ADOC, a PSW and other staff.

[756]