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

Original Public Report

Report Issue Date: May 16, 2023	
Inspection Number: 2023-1513-0002	
Inspection Type: Critical Incident System	
Licensee: Unionville Home Society	
Long Term Care Home and City: Union Villa, Unionville	
Lead Inspector Rexel Cacayurin (741749)	**Inspector Digital Signature** Rexel J Cacayurin Digitally signed by Rexel J Cacayurin Date: 2023.05.17 17:50:21 -04'00'
Additional Inspector(s) Lucia Kwok (752) was present during inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 10, 11, 2023

The following intake(s) were inspected:

- An intake related to falls.

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

Skin and Wound Prevention and Management
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 techniques when assisting a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to resident's fall resulting in an injury. The Registered Practical Nurse (RPN) assessed the resident that was found lying on the floor and suspected an injury. The resident was transferred to the hospital.

The Registered Nurse (RN) along with two PSWs (Personal Support Worker) manually transferred the resident from the floor to bed while waiting for emergency services. The PSW stated they were directed by the RN to manually transfer the resident. The home's investigation notes indicated the same.

A RPN stated that it was not safe to move or transfer resident who are suspected to have injury.

The Director of Care (DOC) stated the home's expectation was not to move the resident who has fallen with suspected injury while waiting for the emergency services. They also indicated that the home has an algorithm in place which staff needed to follow when a resident has fallen. Further the DOC acknowledged it was unsafe to manually transfer the resident after the fall as an injury was suspected.

When staff failed to use safe transfer techniques for the resident post fall, there was risk for further injury.

Sources
CIR, home's fall prevention algorithm, home's internal investigation documents, interviews with the DOC, PSW and RPN

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