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

Ottawa District
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Original Public Report

Report Issue Date: April 26, 2023

Inspection Number: 2023-1132-0002

Inspection Type:
Critical Incident System

Licensee: Crown Ridge Health Care Services Inc.

Long Term Care Home and City: Westgate Lodge Nursing Home, Belleville

Lead Inspector	**Inspector Digital Signature**
Polly Gray-Pattemore (740790)	Pauline L Gray Pattemore Digitally signed by Pauline L Gray Pattemore Date: 2023.05.05 12:53:56 -04'00'

Additional Inspector(s)
Cathi Kerr (641)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18-21, 2023.

The following intake(s) were inspected:

- Intake: #00018767 - CIR#2623-000002-23 was related to alleged neglect.
- Intake: #00019988 - CIR#2623-000006-23 was related to falls prevention and management.

The following intakes were completed in this inspection: Intake #00009002, Intake #00011037 and Intake #00018859 were related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan.

Rationale and summary:

A critical incident report indicated a resident fell and a PSW had independently lifted the resident without the support of another staff.

During interviews with the Inspector, the Administrator and Home Area Nursing Supervisor (HANS) stated that the plan of care for the resident indicated they required extensive assistance for all transfers at the time of the incident.

Failure by PSW to follow the resident's plan of care increased the risk to the safety of resident.

Sources: resident health care record; interviews with the Administrator and the HANS and other frontline staff. [641]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to immediately report improper care of a resident that resulted in harm or a risk of harm, to the Director.

Rationale and summary:

A review of a critical incident report indicated a PSW did not report to their supervisor that a resident had fallen at the time that it occurred. During interviews, the Administrator and Home Area Nursing

Supervisor indicated that PSW did not report the incident to anyone at the time that it occurred as required by ministry legislation.

Failure to immediately report the improper care of a resident could increase the risk to the resident.

Sources: interviews with the Administrator and the HANS. [641]

WRITTEN NOTIFICATION: Transferring and positioning techniques.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that a PSW used safe transferring technique when assisting a resident.

Rationale and summary:

A review of a critical incident report indicated a resident fell and the PSW had independently lifted the resident from the floor into the bed.

During interviews with the Inspector, the Administrator and Home Area Nursing Supervisor indicated that it was the licensee's policy that staff were not to manually lift a resident in any way and should have transferred the resident from the floor by two staff using a mechanical lift.

Failure to use safe transferring techniques by the PSW increased the risk to the safety of resident.

Sources: resident health care record; interviews with the Administrator and the HANS; licensee's Minimal Lift policy 8.0, last reviewed January 2023. [641]