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

Hamilton District
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Original Public Report

Report Issue Date: May 1, 2023	
Inspection Number: 2023-1550-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Gilmore Lodge, Fort Erie	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature** Jonathan Conti Digitally signed by Jonathan Conti Date: 2023.05.18 11:53:05 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11-14, and April 17-19, 2023.

The following intake(s) were inspected:

- Intake: #00019760- [CI: M528-000007-23] was related to abuse of a resident
- Intake: #00021828- Complaint was related to whistleblowing protection, neglect of residents and orientation.

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

Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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

On a day in January 2023, a resident had requested assistance with transfer from a PSW due to their inability to participate as usual with transfer. The resident reported to the PSW that they were unable to utilize their usual assistive device for transferring. As outlined in the resident's care plan for transfers, staff were to report to registered staff any decrease in ability to transfer safely.

The PSW did not report to registered staff the resident's decline in ability to participate in transfer, and instead continued with transfer of the resident. During transfer, the resident stated that they felt pain in their arm.

Interview with the resident confirmed that they felt pain during the transfer with PSW. The Director of Resident Care (DRC) confirmed with inspector that staff were trained on the policy and procedures for safe transferring requirements of residents and that the PSW was expected to do an assessment prior to transfer and if required, to obtain additional assistance from other staff members.

The Clinical Documentation Informatics Lead (CDI Lead) confirmed with inspector that the PSW did not report the incident to registered staff. The home's management team were not made aware of the incident until informed by the resident's family. The resident was taken to Urgent Care on the same date as the incident. The post-hospital assessments completed by long-term care home staff confirmed that the resident had an injury.

By the PSW not using safe transferring techniques, the resident sustained an injury.

Sources: Interviews with resident, PSW, DRC, and CDI Lead; CI Report M528-00007-23; resident care plan and clinical records; homes policy titled Lift and Transfer - Back to C.A.R.E, reference number RKM00-011, revised January 23, 2023; PSW training records.

[740882]