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 July 25, 2022
Inspection Number 2022_1558_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Hastings

Long-Term Care Home and City
Hastings Manor Home for the Aged
Belleville, ON

Lead Inspector
Darlene Murphy (103)

Inspector Digital Signature
Darlene Murphy
Digitally signed by Darlene Murphy
Date: 2022.07.25 10:32:32 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 13-15, 19-20, 2022.

The following intake(s) were inspected:

- Log #008701-22 (CIS #M538-000025-22), Log #009546-22 (CIS #M538-000026-22) and Log #010479-22 (CIS #M538-000028-22)-related to resident falls,
- Log #011120-22 (CIS #M538-000029-22)-related to an alleged resident abuse,
- Log #010550-22 (Complaint)-related to resident care.

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 FALLS PREVENTION AND MANAGEMENT

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

Non-compliance with: O. Reg. 246/22 s. 54 (1)

The licensee has failed to comply with the policy to ensure the slings used for resident transfers were in good condition.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have strategies in place to mitigate falls with the use of devices and that the strategy is complied with.

Specifically, staff failed to comply with policy, "Transfers and Lifts" dated June 2022 by failing to check the condition of the sling used prior to completing the lift/transfer to ensure it was in good condition.

Rationale and Summary
A resident sustained a fall from the sling when one of the straps broke while being transferred using a mechanical lift. Upon inspection of the sling used, it was determined the one strap had some tearing/fraying evident which failed during the transfer. A Registered Practical Nurse (RPN) and Director of Nursing (DON) both indicated the expectation is that staff carefully inspect the slings prior to each transfer to ensure there is no evidence of damage. Failing to do so, places residents at risk of serious injury.

Sources: resident progress notes, Lifts and Transfer Policy and interview with an RPN and DON.

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