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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 20, 2024

Inspection Number: 2024-1133-0004

Inspection Type:
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Summit Place, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9-10, 13, 17-18, 2024
The inspection occurred offsite on the following date(s): December 12, 2024

The following intake(s) were inspected:

- Intake: #00129062, related to neglect and care concerns
- Intake: #00129860, related to an injury of unknown cause
- Intake: #00130542, related to neglect and care concerns
- Intake: #00131089, related to safe transfers

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a resident was transferred safely resulting in injuries.

Rationale and Summary
A resident was being transferred by two PSW's when the resident slipped out of the sling onto the floor.

During the homes investigation one of the PSW's said they noticed the bottom right pin hook on the sling was not secured, and as a result the resident slid from the sling.

A Housekeeper said when they moved the sling and rolled it up, there were no bones in it.

The ED confirmed that the bones should have been in place in the sling, and the pins should have been checked to ensure they were secure prior to the transfer occurring.

Failing to check the bones were in the sling and the pins were secured to the lift resulted in the resident falling from the sling and sustaining injuries.

Sources: CIS report, Resident's clinical records, Resident Safe Lift and Transfer Policy, interviews with Housekeeper and Executive Director (ED)