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

Original Public Report

Report Issue Date: April 30, 2024
Inspection Number: 2024-1377-0002
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Halton Hills, Georgetown

Lead Inspector	**Inspector Digital Signature**
Mark Molina (000684)	Mark Molina Digitally signed by Mark Molina Date: 2024.04.30 15:06:47 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23-25, 2024

The following intake(s) were inspected:

- Intake: #00109617 - [CI 2892-000016-24] - related to injury of unknown cause

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

Resident Care and Support Services
Infection Prevention and Control

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 has failed to ensure that staff used safe transferring when assisting a resident.

Rationale and Summary
Staff transferred a resident twice using a technique that was not safe. The resident complained of pain afterwards.

Failure to ensure that staff used safe transferring technique identified in the resident's plan of care, put a resident at risk for injury.

Sources: Home's investigation notes; Resident's clinical records; Interviews with staff.
[000684]