

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Ottawa District**  
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<b>Original Public Report</b>	
<b>Report Issue Date:</b> December 29, 2022	
<b>Inspection Number:</b> 2022-1380-0001	
<b>Inspection Type:</b> Critical Incident System	
<b>Licensee:</b> Deep River and District Hospital	
<b>Long Term Care Home and City:</b> The Four Seasons Lodge, Deep River	
<b>Lead Inspector</b> Lisa Cummings (756)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b>	

<b>INSPECTION SUMMARY</b>
<p>The Inspection occurred on the following date(s): December 5-7, 2022</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> <li>• Intake #00001607, (CI #2896-000001-22) Allegation of resident to resident abuse.</li> <li>• Intake #00012592, (CI #2896-000004-22) Allegation of staff to resident neglect.</li> </ul>

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Transferring and positioning techniques

**NC #01 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 safe transferring techniques were used with a resident.

A PSW explained they found the resident in their room with the resident's transfer sling left partially attached to a mechanical lift. The DOC stated leaving a resident's transfer sling attached to a mechanical lift was not proper practice and that the resident would have been restrained in place due to this.

The resident did not experience harm from the incident, but there was an increased risk of injury as a result of the partially attached sling keeping the resident in place and the remote within arm's length.

Sources: Resident healthcare record, interviews with a PSW and the DOC.

[756]