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: November 25, 2024
Inspection Number: 2024-1108-0002
Inspection Type: Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Harriston, Harriston

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 13 - 14 and 19 - 20, 2024.

The following intake was inspected in this Critical Incident (CI) Inspection:

- Intake: #00126373 was related to falls prevention and management

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

Infection Prevention and Control
Pain Management
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 has failed to ensure that staff members used safe transferring and positioning devices or techniques when assisting a resident after a fall.

Rationale and Summary
A resident had a witnessed fall and the resident was assisted from the floor by two staff members.

The home's No Lift Policy indicated that after a resident has been deemed safe to be lifted from the floor, a full sling mechanical lift will be used. Team members are not permitted to physically lift the resident off the floor.

The Falls Lead confirmed that the home has a no lift policy and that a Hoyer lift should have been used to transfer the resident from the floor post-fall and said this was not done.

When unsafe transferring techniques were used after a resident fell, it increased the risk of worsening any potential injuries sustained during the fall.

Sources: A resident's Clinical Records, The home's No Lift Policy (Policy Number LTC-NURS-S13-60.0), last reviewed January 29, 2024, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that a resident had their falls prevention interventions available to reduce the likelihood of a resident fall.

Rationale and Summary
A resident was at risk for falls and had an intervention in place for falls prevention and management.

The fall prevention intervention was not in place when the resident had a fall.

When the resident's fall prevention intervention was not in place and functioning, it put them at risk of falls.

Sources: A resident's Clinical Records, The home's Fall Management Program - Interdisciplinary Team (Policy number LTC-NURS-S10-20.0), last reviewed March 8, 2024, and interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the

following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to ensure that a resident was monitored for the responses to, and the effectiveness of their pain management strategies.

Rationale and Summary
A resident returned from hospital after an acute incident, with a new onset of pain and an inability to weight bear.

The home's Pain Management Program Policy directed the registered nurse to re-initiate the 72-hour Pain Screening Tool and Comprehensive Assessment when a resident returned from a hospital stay, with any change in their analgesia orders, with new complaints or indications of pain, and with any significant change in status.

The 72-hour Pain Screening Tool was not initiated upon the resident's return from hospital, when the resident had an analgesic medication change upon their return from hospital or when they expressed a new onset pain.

The Pain Lead confirmed that registered staff did not complete the 72-hour Pain Screening Tool for the resident when they returned from hospital and stated that this should have been done.

The Director of Care (DOC) stated that staff should have been monitoring the resident's pain by completing pain assessments.

By failing to monitor and assess the effectiveness of the resident's pain management strategies, the resident was at risk of improper pain management.

Sources: A resident's Clinical Records, The home's Pain Management Program

Procedure Policy (Policy Number LTC-NURS-S5-20.0), Last reviewed March 5, 2024, and interviews with staff.