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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 5, 2024
Inspection Number: 2024-1030-0001
Inspection Type: Critical Incident
Licensee: Dover Cliffs Operating Inc.
Long Term Care Home and City: Dover Cliffs, Port Dover

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.02.05 13:22:07 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00095216, CIS #1056-000010-23, related to a resident's fall.
- Intake: #00103073, CIS #1056-000013-23, related to an outbreak.
- Intake: #00107727, CIS #1056-000004-24, related to resident's responsive behaviours.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care for a resident was based on the assessment and the needs of the resident.

Observation during inspection showed a resident had a specific intervention related to responsive behaviours.

In an interview two registered staff members confirmed the resident was receiving the intervention based on their assessed needs. They reviewed the plan of care and said there was no indication in the plan of care about the intervention. A registered Nurse updated the plan of care to ensure it was based on the assessed need of the resident.

Sources: observation, record review and staff interview. [523]
Date Remedy Implemented: February 2, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure the plan of care for a resident was based on, at a minimum, interdisciplinary assessment of the resident's risk for falls.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to resident's fall.

A clinical record review for the resident showed they were assessed for fall risk on admission.

A clinical record review showed the plan of care was not based on the interdisciplinary assessment of the resident's risk for falls.

In an interview Director of Care confirmed the resident's plan of care initially was not based on the interdisciplinary assessment of the resident's risk for falls but the plan of care was updated at a later date. They said the resident's fall risk interventions were implemented even though they were not documented.

The resident was put at risk by not having their fall risk interventions in the plan of care.

Sources: record reviews and staff interviews. [523]