Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 28, 2021	2021_885601_0008	021075-20, 000285-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Fosterbrooke
330 King Street West Newcastle ON L1B 1G9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 15, and 16, 2021.

The following intakes were completed in this Critical Incident System (CIS) Inspection:

A log related to a resident missing for less than three hours.

A log related to an unexpected change in a resident's condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Support Services Worker(SSW), and a resident.

The inspector also reviewed resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions, and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the clinically appropriate post-fall assessment initiated for a resident following a fall was fully completed to include the specifically designed factors to analyze the root cause of the fall.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report regarding an unexpected change in a resident's condition, that occurred a specified number of days after the resident had been found on the floor with no injuries.

The licensee’s falls prevention policy directed the nurse to immediately complete a "Post-Fall Assessment" following a resident fall. The Post-Fall Management procedure directed to conduct an interdisciplinary team huddle on the same shift that a resident falls to collect the information needed to conduct a root cause analysis of the fall.

Staff interviews and record review identified the resident was a high risk for falls and falls preventions measures were in place.

The ADOC indicated the resident did not sustain an injury when they were found on the floor and they had reported their assessment of the resident to the RN. The ADOC further indicated they could not recall the details of the fall and if the resident’s falls prevention measures were in place when the resident was found on the floor. The RN documented a post-fall huddle was not completed following the resident’s fall. The Risk Management post-fall assessment did not include the information required to conduct a root cause analysis of the fall.

Staff indicated an interdisciplinary team huddle should be held following a resident fall to collect the information needed to conduct a root cause analysis of the fall. They further indicated the post-fall assessment included predisposing factors that could put the resident at risk for falls and should be completed by the registered staff following a resident fall. The ADOC and DOC both acknowledged the information needed to conduct a root cause analysis of the fall was not completed by the RN when the resident was found on the floor.

Failure to complete the required post-fall assessment related to the predisposing factors could place the resident at increased risk for future falls, if the root cause of the fall was not analyzed.

Source: CIS, Falls Prevention and Injury Reduction policy Falls/Restraint Meeting minutes, a resident plan of care, structured falls progress note, and the Risk Management Post-Fall Assessment, interviews with PSW, RPN, ADOC, and the DOC. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 14th day of May, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.