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
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Original Public Report

Report Issue Date: February 2, 2024	
Inspection Number: 2024-1102-0001	
Inspection Type: Critical Incident	
Licensee: Clurelea Ltd.	
Long Term Care Home and City: Good Samaritan Nursing Home, Alliston	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2024.02.02 13:10:55 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 29, 30, 2024.

The following intakes were completed during this Critical Incident (CI) Inspection:
· Intake: #00102204 and Intake: #00105509 related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PASDs THAT LIMIT OR INHIBIT MOVEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4)

The licensee failed to meet the requirements for inclusion of a Personal Assistance Service Device (PASD) in a resident's plan of care, as set out in the FLTCA, 2021.

Rationale and Summary

A resident used a PASD as part of their care.

There was no documentation in the resident's clinical health records indicating the approval by a physician, Registered Nurse (RN), Registered Practical Nurse (RPN), Occupational Therapist (OT), or Physical Therapist (PT), for the use of the PASD, nor was there consent provided by the resident's Substitute-Decision Maker (SDM). Furthermore, the resident's care plan, Kardex, and Point of Care (POC) tasks, did not outline information regarding PASD use.

There was moderate risk related to the lack of approval and clarity on the use of the PASD, as it may not have been consistently utilized for its purpose.

Sources: Resident's clinical health records, the home's investigation notes, Critical Incident (CI) report, PASD policy effective October 2023; Interviews with the Personal Support Workers (PSWs), RN, the Director of Resident Care (DRC), and the

Administrator. [653]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including interventions and the resident's responses to interventions were documented.

Rationale and Summary

The home's PSW Documentation policy indicated that the Point of Care (POC) online documentation will be used to show evidence of care provided to the resident by the assigned caregiver including, but not limited to dressing, feeding, transfers, toileting, mobility aids, hygiene, behaviours and continence care. The PSWs will only record care after it has been provided to the resident, each shift of every day.

A PSW did not provide care to a resident on a particular shift, however, documented on POC that care was provided at that time.

The Administrator indicated that the home's expectation was for PSWs to document on POC after care had been provided to the residents.

By incorrectly documenting the resident's care, other staff would not have been alerted that the resident's care was not completed.

Sources: Resident's clinical health records, the home's investigation notes, CI report,

PSW Documentation policy effective October 2023; Interviews with the Administrator, DRC, and other staff. [653]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure that a strategy to reduce or mitigate falls, was implemented by a PSW.

Rationale and Summary

A resident was at risk for falls, and one of the interventions in their care plan was the placement of a device when the resident was in bed.

On one occasion, the resident had an unwitnessed fall resulting in injuries. The falls prevention intervention was not in place and working at the time of the fall incident.

By not ensuring that the intervention was in place and working, the device did not go off when the resident had fallen out of their bed.

Sources: Resident's clinical health records, the home's investigation notes, CI report, the home's Fall Prevention and Management policy effective September 2023; Interviews with the DRC, and the Administrator. [653]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee failed to ensure that a resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required.

Rationale and Summary

A resident's care plan indicated that they were totally dependent on staff for turning and repositioning, and they required two staff assistance to turn and reposition in bed at least every two hours.

The resident was not turned and repositioned every two hours by the staff for a period of six hours.

By not turning and repositioning the resident every two hours for a period of six hours, there was a potential risk for discomfort and skin breakdown.

Sources: Resident's clinical health records, the home's investigation notes, CI report; Interviews with the DRC, and the Administrator. [653]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that a resident's plan of care for continence was implemented.

Rationale and Summary

A resident's plan of care for continence provided interventions to manage their care.

This intervention was not implemented for a period of six hours.

By not implementing the intervention for continence, there was a potential risk for discomfort and developing altered skin integrity.

Sources: Resident's clinical health records, the home's investigation notes, CI report; Interviews with the DRC, and the Administrator. [653]