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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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: May 13, 2024	
Inspection Number: 2024-1401-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.05.23 13:51:59 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18 - 19, 22, 24 - 25, 2024

The following intake(s) were inspected:

- Intake: #00109663 - Resident fall resulting in injury and change in status
- Intake: #00114011 - Complaint related to responsive behaviors

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

Infection Prevention and Control
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 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 failed to comply with their Fall Prevention and Management Program when they did not provide a resident with the strategies, equipment and devices required to reduce and mitigate their falls.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that after a resident has fallen, interventions are to be initiated to prevent a similar recurrence and will be documented. In addition, it states the resident's plan of care is to be reviewed, outlining interventions and prevention methods.

Specifically, staff did not comply with the home's policy, Fall Prevention and Management, revised May 2022, which was included in the home's Fall Prevention and Management Program.

Rationale & Summary

A resident experienced multiple falls over a period of time. Their final fall resulted in an injury and they later passed away.

The resident was high risk for falls. However, nursing staff conducted multiple fall assessments stating they were low risk for falls. The assessments included inaccurate data and for this reason, additional fall prevention interventions were not implemented for this resident.

When alternative interventions were not initiated to prevent a recurrence of falls for the resident, they were placed at risk of injury.

Sources: Clinical record review for the resident, the home's Fall Prevention and Management policy (RCM 10-02-01, revised May 2022), interview with staff.

[000685]