

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

| | |
|--|------------------------------------|
| Report Issue Date: November 17, 2023 | |
| Inspection Number: 2023-1497-0005 | |
| Inspection Type: Complaint Critical Incident Follow up | |
| Licensee: Maxville Manor | |
| Long Term Care Home and City: Maxville Manor, Maxville | |
| Lead Inspector Laurie Marshall (742466) | Inspector Digital Signature |
| Additional Inspector(s) Gabriella Kuilder (000726) Maryse Lapensee (000727) | |

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 18, 19, 20, 23, 25, 2023

The following intake(s) were inspected:

- Intake #00098364 related to a complaint regarding visitation of a resident.
- Intake # #00095062, CI:3000-000010-23 incident resulting in unexpected death.
- Intake ##00098737, CI:3000-000012-23 related to a complaint regarding the improper/incompetent care of a resident.
- Intake: #00087986, CI:3000-000005-23 relating to fall resulting in significant injury.
- The following intakes were completed in this inspection: Intake: #00086243, CI:3000-000004-23; Intake: #00089941, CI:3000-000006-23; Intake: #00090304, CI:3000-000008-23 were related to an injury with a significant change in condition.
- Follow-up intake #94757 relating to O. Reg. 246/22, s. 135.

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

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Residents' Rights and Choices
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

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

According to the Critical Incident Report (CIR), on September 29, 2023, two Personal Support Worker's (PSW) used a Sit to Stand lift to toilet a resident, which resulted in an injury.

In the resident plan of care stated it that they were to be transferred by an alternate method than what was used for toileting.

Two PSW's confirmed that they used the Sit to Stand lift to transfer the resident when toileted.

The physiotherapist (PT) stated that the Sit to Stand lift was to be used if a resident meets the following three important criteria:

- must put at least 50% weight on one leg.
- be able to sit without support and
- be able to follow instructions.

Assessment conducted by the PT indicated that the resident was unable to weight bear and needed assistance to sit.

A Registered Practical Nurse (RPN) and the Director of Care (DOC) confirmed that the resident was not a candidate to use the sit to stand lift because of their health condition and not being able to weight bear.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

By transferring the resident with a Sit to Stand lift, the resident sustained an injury.

Source: Resident health records; CIR, interview with PSW staff, RPN, DOC and PT.

[000727]

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the home's policy for fall prevention and management program was complied with for resident two residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury and it must be complied with.

Rationale and Summary

#1

Specifically, staff did not comply with "Assessing falls and their causes", which was included in the licensee's Falls Prevention and Management Program.

The Falls Prevention and Management policy directed, under section Assessing fall and their causes, the staff to follow these steps after a fall:

"a. If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities." and
"c. once an assessment rules out significant injury, nursing staff will help resident to a comfortable sitting, lying or standing position, and then document relevant details."

A PSW confirmed that the first resident slid off their bed, and with the help of another PSW they put the resident back to bed before notifying the nurse of the fall.

A Risk management assessment was completed and indicated that the nurse was not notified of the incident right away.

The DOC confirmed that the home's expectation after a resident had a fall was to notify the nurse immediately, and on the day of the incident, the two PSW's didn't follow the post fall policy when they didn't notify the nurse when the resident slid from their bed.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

By not complying with the Fall Prevention and Management policy, the resident was placed at an increased risk of significant injury post fall.

Source: The Resident health records, Falls Prevention and Management Program Policy, Interview with PSW and DOC. [000727]

#2

Specifically, staff did not comply with “Assessing falls and their causes”, which was included in the licensee’s Falls Prevention and Management Program.

section 1. (c) once an assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.

Progress notes documented that the second resident was found on the floor after sustaining a fall in a co-resident’s room. According to progress notes created by the RPN and RN, a post fall assessment was completed, and a significant injury was suspected. PSW staffs were directed not to move the resident off the floor, until paramedics arrive. The RN and RPN left the area to notify the resident’s substitute decision-maker, attending physician, and paramedics to transfer resident to hospital. When the RPN, and RN returned to the room the resident was moved off the floor on to a bed. The PSW staff indicated that the RN had directed them to move resident off the floor.

The RN completed a late entry progress note regarding the fall of the resident for this incident. The documentation indicated they directed four PSW staff to lift resident off the floor on to the bed, to provide resident with comfort.

During interviews with Interim Director of Care (DOC), RPN, RN, and PSW, it was confirmed when a resident has fallen prior to moving them off the floor a post fall assessment is completed. If a significant injury is suspected then resident is not to be moved, until paramedics arrive to transfer resident to hospital.

By not ensuring the home's policy for Falls Prevention and Management was complied with, the resident was placed at an increased risk of significant injury post fall.

Source: Resident’s health records, Falls Prevention and Management Program Policy, Interview with PSW, RPN, RN and DOC. [000726]



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

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559



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

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559