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

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Original Public Report

Report Issue Date: January 26, 2024
Inspection Number: 2024-1497-0001
Inspection Type: Critical Incident
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

Lead Inspector	**Inspector Digital Signature**
Shevon Thompson (000731)	Shevon M Thompson Digitally signed by Shevon M Thompson Date: 2024.01.30 10:39:56 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 17, 18, and 22, 2024

The following intake was inspected:

- Intake: #00105338 - Related to a fall of a resident.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written care plan and kardex documents, that were available to staff for a resident, sets out clear directions on the use of fall prevention and transferring devices to staff and others who provide direct care to the resident.

Rationale and Summary:
In January, 2024, inspector noted a resident in their room using specific falls prevention devices. The following day inspector noted an additional device was in place.
A review of the resident's progress notes documented in December, 2023 validated that a specific device had been implemented for the resident. Another progress note on the same date further clarified when the device was to be used for the resident. In a review of staff's unit work sheet, on a specific date in January, inspector noted that the task for falls prevention for the resident included ensuring that three of the devices were in place. Upon review of the resident's current kardex,

available to the staff, there was no documentation of the falls prevention devices or the device used for transferring the resident.

In an interview with staff, they verified that two devices were in place for falls prevention before the resident's fall in December of 2023. They validated that other devices had been added after the resident's fall. A staff validated that the resident used the devices for falls prevention and confirmed that the resident used a another device for transferring. During an interview, a registered staff reviewed a printed copy of the resident's written care plan and confirmed that they were unable to find the falls prevention devices in the resident's written care plan. In an Interview with the Director of Care (DOC) and the Assistant Director of Care (ADOC), after a review of the printed copy of the resident's written care plan, they confirmed that the falls prevention devices were not included in the resident's written care plan.

Failure to ensure that the written care plan and kardex for the resident sets out clear directions, on the use of falls prevention and transferring devices to staff and others who provide direct care to the resident, places the resident at increased risk for falls and injury.

Source: observations of resident's room, resident's electronic and written records and interviews with staff, DOC and ADOC.
[000731]

WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 11.
Training
Orientation

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that a specific staff did not perform their responsibilities before receiving training in the areas mentioned below, specifically in any other areas provided for in the regulations. In accordance with O. Reg. 246/22 s. 261 (1) 1. For the purposes of paragraph 6 of subsection 87 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents. Falls prevention and management.

Rationale and Summary:
The home was unable to provide a record of Falls prevention education and training for a specific staff. In an interview with the staff, they confirmed that they had not completed education and training for falls prevention at the home. The Director of Staff Development, (DOSD), confirmed that the staff had not completed falls prevention education and training at the home.
Failure to ensure that a staff did not perform their responsibilities before receiving education and training in falls prevention placed the resident at an increased risk.

Source: Interview with staff and DOSD. [000731]

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)
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 has failed to ensure that the falls prevention and management program was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any, plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with. Specifically, the licensee has failed to initiate and complete a head injury routine (HIR) for a resident after a fall.

Rationale and Summary:
From a review of the home's Fall Prevention and management policy, page 6 section C 2, Post-Fall Management, inspector noted that staff are to initiate Head Injury Routine (Neurological Assessment) and assess the resident's level of consciousness if a head injury is suspected. In a progress note a staff documenting that the resident had an unwitnessed fall with head injury routine. A further progress note, noted that the head injury routine was to continue. A review of the resident's physical chart noted a HIR for the resident's previous fall which included assessments on the day, evening and night shifts. During a review of the physician's binder there was no head injury routine noted for the resident's fall on that specific date. A registered staff stated that when a resident had fallen and was on a Head Injury Routine (HIR) and had another fall during the time of the HIR the registered staff was expected to start a new HIR. Another registered staff verified that when a

resident had an unwitnessed fall the registered staff would complete a Head Injury Routine (HIR). They confirmed that if during the time of the HIR the resident had a new fall then the previous HIR would be cancelled and a new HIR would be started using a new sheet. In an interview with the DOC and the ADOC, they stated that the expectation of the registered staff was to complete a head injury routine after every unwitnessed fall using a new form. After reviewing the HIR for a specific date, the DOC confirmed that it did not capture the HIR for the resident's fall on the date in question.
Failure to ensure that the fall prevention and management program is complied with places the resident at an increased risk for any changes in their condition to go unnoticed and untreated.

Source: home's Fall Prevention and management policy, resident's physical chart including physician's binder, Interviews with registered staff, DOC and ADOC. [000731]p

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:
In review of the resident's electronic record and physical chart inspector noted no post fall assessment completed for the resident's fall on a specific date in December of 2023. During an interview with a registered staff, they confirmed that when a resident had fallen a post fall assessment should be completed using the post fall assessment tool found under the assessment tab in PointClickCare. However, after a review of the resident's electronic chart the registered staff was unable to find a post fall assessment completed for the resident. The registered staff further confirmed that they had not completed a post fall assessment. In an interview with the DOC and the ADOC they verified that the registered staff was expected to complete a post fall assessment when a resident had fallen and confirmed that a post fall assessment had not been completed for the resident fall on a specific date in December of 2023. .
Failure to complete a post fall's assessment may delay determining the cause of the fall and implementing any necessary post fall's interventions.

Source: resident's electronic and physical records, interview with registered staff, DOC and ADOC. [000731]