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

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

# Original Public Report

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| **Report Issue Date:** December 5, 2023 | |
| **Inspection Number:** 2023-1605-0005 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** The Regional Municipality of Niagara | |
| **Long Term Care Home and City:** Northland Pointe, Port Colborne | |
| **Lead Inspector**<br>Betty Jean Hendricken (740884) | **Inspector Digital Signature**<br>Elizabeth J Hendricken<br>Digitally signed by Elizabeth J Hendricken<br>Date: 2023.12.11 12:46:40 -05'00' |
| **Additional Inspector(s)**<br>Lesley Edwards (506) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 16, 17 and 20, 21 and 23, 2023.
The inspection occurred offsite on the following date(s): November 22, 2023.

The following intake(s) were inspected:

- Intake: #00097746 - (critical incident) related to falls prevention and management.
- Intake: #00098178 - (critical incident) related to falls prevention and management.
- Intake: #00099720 - (critical incident) related to infection prevention and control.
- Intake: #00100001 - (critical incident) related to falls prevention and management.

The following intakes were completed:

- Intake: #00101198 - (critical incident) related to falls prevention and management.
- Intake: #00092207 - (critical incident) related to falls prevention and management.
- Intake: #00100537 - (critical incident) related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
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)

The licensee has failed to comply with the falls prevention and management program when a resident sustained a fall and required monitoring.

**Rationale and Summary**
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure when a resident falls, the status of the resident is monitored for 48 hours and will be documented in the resident's progress notes. A Glasgow coma scale must also be

initiated for unwitnessed and witnessed falls or other medical related criteria, for a total of seven times at required intervals. Specifically, staff did not comply with the licensee's policy for "Falls Prevention and Management", revised September 2023, which was included in the licensee's Resident Care and Services Manual.

The resident's clinical record identified the resident sustained falls on dates on two specified dates. Review of the clinical record identified that progress notes were not consistently completed for every shift for 48 hours and the Glasgow coma scale was not completed at the required intervals for both falls.

Failure to follow the Falls Prevention and Management policy as required had the potential for the resident to not be assessed for injuries in a timely manner.

**Sources:** Review of resident's clinical record; review of the home's policy Fall Prevention and Management (PCS04-011, revised September 2023); interviews with Director of Care (DOC) and other staff.
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