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 July 28, 2022
Inspection Number 2022_1574_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee

Board of Management of the District of Kenora
1220 Valley Drive, Kenora, ON, P9N-2W7

Long-Term Care Home and City

Pinecrest (Kenora)
1220 Valley Drive, Kenora, ON, P9N-2W7

Lead Inspector
Amy Geauvreau #642

Inspector Digital Signature
Amy Geauvreau
Digitally signed by Amy Geauvreau
Date: 2022.08.02 05:59:00 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13-17, 2022

The following intake(s) were inspected:

- Two intakes related to falls with injuries.
- One intake related to fluid intake, and recreational activities.

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Recreational and Social Activities
- Safe and Secure Home

INSPECTION RESULTS FALLS PREVENTION AND MANAGEMENT

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

O. Reg. 246/22, s. 54. (1)

The licensee has failed to comply with the Falls Prevention and Management program and initiate a specific protocol when two resident's had unwitnessed falls.

Rationale and Summary

In accordance with O. Reg. 79/10, s. 8 (1) (b), the licensee is required to ensure the home's Fall Prevention and Management policy was complied with.

O. Reg. 226/22, s. 54 (1) requires that the program includes strategies to reduce or mitigate falls, including the monitoring of residents after falls.

Specifically, staff did not comply with a specific protocol, which was included in the home's policy "Falls Prevention and Management Program."

1) A resident had a fall incident, which caused an injury.

A Registered Practical Nurse (RPN), who had completed the resident's fall assessments that day, identified, that the fall was unwitnessed and that for any unwitnessed fall, a specific assessment form should have been completed. However, upon review of the resident's assessments, the specific protocol had not been completed.

Sources: CIS; review of the resident's health records; the home's policy titled, "Falls Prevention and Management Program", last revised May 2021, and specific protocol; and interviews with a RPN, the Director of Care (DOC), and Assistant Director of Care (ADOC), and other staff.

2) A resident had a fall incident with an injury.

The RPN, who had completed the resident's fall assessments, identified, that the fall was unwitnessed and that for any unwitnessed fall, a specific assessment form should have been completed. However, upon review of the resident's assessments, the specific protocol had not been completed.

The DOC identified that the specific assessments should be completed for any unwitnessed fall as per the falls policy.

Sources: CIS; review of a resident's health records; the home's policy titled, "Falls Prevention and Management Program", last revised May 2021, and a specific protocol; and interviews with the RPN, the DOC, and ADOC, and other staff. [#642]