Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2020	2020_765541_0007	001935-20	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

The Village Green Nursing Home
166 Pleasant Drive P.O. Box 94 Selby ON K0K 2Z0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 23-24, 2020

The following log was inspected during this inspection:
Log #001935 related to a resident fall

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Registered Nurse and a Personal Support Worker. In addition, the inspector reviewed the licensee's fall prevention policy.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On a specified date, resident #001 sustained a fall. A post-fall assessment was not documented until 4 days after the fall. The post-fall assessment did not include any vitals, there was no assessment of the resident's pain, no details of the resident's activity at the time of the fall and no indication that the resident's family was contacted. A review of the resident's progress notes on the date the fall occurred, demonstrated there were no notes entered to indicate the resident had fallen nor were there any post-fall assessments documented. There were no vitals nor other assessments documented on the date of the fall. Approximately 24 hours following resident #001's fall, the resident was sent to hospital where they were diagnosed with a fracture.

PSW #102 was interviewed and stated they were assisting resident #001 with care when the resident's legs "buckled" and the resident fell on the floor. RN #101 was interviewed and stated they were unaware the resident had fallen when they were called to assist the resident off the floor. RN #101 further stated a post-fall assessment was not completed as their understanding was the resident had slipped from the toilet and because the resident was able to ambulate.

An interview with the DOC indicated the expectation would be for a post-fall assessment to be completed within 24 hours of the resident's fall.

The licensee failed to ensure that resident #001 received a post-fall assessment using a clinically appropriate assessment instrument. Resident #001 was later diagnosed with a fracture. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 11th day of August, 2020

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.