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: December 4, 2024
Inspection Number: 2024-1448-0005
Inspection Type: Critical Incident
Licensee: The Women's Christian Association of London
Long Term Care Home and City: McCormick Home, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21-22, and 25-26, 2024.

The following intake was inspected:

- Intake: #00129169 related to a resident fall with injury

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: O. Reg. 246/22, s. 29 (3) 10.

Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee failed to ensure a resident's plan of care was based on an interdisciplinary assessment of the resident's health condition.

Rationale and Summary
A resident fell and sustained an injury, for which they were sent to the hospital. A diagnostic test performed at the hospital indicated a health condition. The health condition was not verbally reported to the home upon the resident's return.

A Registered Nurse (RN) acknowledged they had not reviewed all the documentation that had been sent from the hospital. The RN filed the discharge package for the resident's attending physician to review during the physician's next rounds.

The resident's attending physician stated that if they had known the positive result of the diagnostic test indicating the health condition, they would have revised the resident's plan of care. The Director of Care (DOC) acknowledged that the information given to the resident's attending physician upon discharge from hospital was incomplete.

The resident's plan of care was based on incomplete information, as it did not include an interdisciplinary assessment of a health condition diagnosed with testing completed in hospital. As a result, the resident and their family were not promptly offered all available care options for the health condition.

Sources: Review of the resident's health care records, and staff interviews.

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.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to comply with their written falls prevention and management program.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure there is a written program for falls prevention and management, and this program must be complied with.

Specifically, staff did not comply with the falls prevention and management program by not completing an assessment form, as per the scheduled time intervals, after a resident fell and sustained an injury.

Rationale and Summary
The home's Post Fall Assessment policy required that an assessment form be initiated and completed for any resident with a specific type of injury, as detailed in another of the home's policies. This other policy also specified that the assessment form must be completed at the scheduled time intervals.

A resident fell and sustained an injury that required an assessment form to be completed according to the home's policies. The assessment form was initiated, scheduling times for assessment. However, multiple assessments were not

completed because the resident was sleeping. The resident refused all the other attempted scheduled assessments.

The resident's attending physician expected that a resident with this type of injury would have had all the scheduled assessments completed.

Failing to complete the necessary assessments may have delayed the timely diagnosis of the health condition.

Sources: Review of the resident's health care records, and the home's Post Fall Assessment policy and other policies, and staff interviews.