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

Report Issue Date: November 27, 2024

Inspection Number: 2024-1156-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Streetsville Community, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7-8, 2024 and November 12-13, 2024

The following intake(s) were inspected in the Critical Incident (CI) section: Intake: #00122532/CI#2648-000008-24 - related to falls prevention and management

Intake: #00122920/Follow-up #2 - High Priority Compliance Order (CO) from inspection #2024-1156-0001 regarding O. Reg 246/22, s. 74 (2) (c) Nutritional Care and hydration program

The following intakes was completed in this inspection:

Intake: #00126422/ CI#2648-000010-24 - related to falls prevention and management
Intake: #00126616/ CI#2648-000011-24 - related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1156-0001 related to O. Reg. 246/22, s. 74 (2) (c)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident had an unwitnessed fall. The staff attended to the resident after they heard the resident yell out. Staff transferred the resident from the floor to their bed. A staff acknowledged that the resident was in pain and was guarding their right hip prior to the transfer.

The Long-Term Care Homes (LTCH) policy "Falls Prevention and Management"

revised October 2024, states, when a fall occurs, all team members will ensure the resident is not moved before the completion of a preliminary assessment.

A staff confirmed that staff did not do a preliminary assessment prior to transferring the resident to their bed.

Associate Director of Care (ADOC) confirmed that staff should have waited until an assessment was completed by a registered staff prior to transferring the resident.

Failure to transfer the resident before an assessment was completed posed a safety risk.

Sources: Policy "Falls Prevention and Management" revised October 2024, CI #2648-000008-24 and interview with staff.

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 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

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

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program provides for assessment and re-assessment instruments.

Specifically, staff did not comply with the policy "Falls Prevention and Management" originated June 2003 and revised October 2024.

Rationale and Summary

A resident sustained an unwitnessed fall. Staff found the resident on the floor. The staff transferred the resident from the floor to their bed. A staff completed a falls risk assessment however, no Head Injury Routine (HIR) assessment was completed. Afterwards, the resident was transferred to the hospital that resulted in an injury.

The Long-Term Care Homes (LTCH) policy "Falls Prevention and Management" revised October 2024, states initiate a head injury routine for all unwitnessed falls. A review of a resident's clinical record and no HIR was completed.

ADOC acknowledged that an HIR assessment was not completed and that it should have.

Failure to complete an HIR after the resident had an unwitnessed fall lead to a potential risk to the resident's safety and wellbeing.

Sources: Policy "Falls Prevention and Management" revised October 2024 and interview with staff.

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NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Complied for second follow up

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.