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: November 14, 2023	
Inspection Number: 2023-1343-0006	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Hamilton, Hamilton	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2023.11.15 13:19:25 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1-3, 6 and 7, 2023.

The following intake was completed during this Critical Incident (CI) inspection: inspected:

- Intake #00098208 (CI 2858-000014-23) related to falls prevention and management.

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

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 monitoring of a resident after unwitnessed falls.

In accordance with Ontario Regulations 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a fall prevention and management program that provides strategies to mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program", dated March 2023, which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
The home's Fall Prevention and Management Program required registered staff to monitor residents after an unwitnessed fall using the clinical monitoring records which required documenting on neuro-vital signs, vital signs, pain and motor responses resulting in a score on the Glasgow Coma Scale. The monitoring schedule required an initial neuro check, hourly checks for four hours and then every eight hours for 72 hours post fall.

A resident experienced multiple unwitnessed falls. A review of the clinical monitoring records showed that three separate neuro checks were not completed. Five neuro checks scheduled to be performed every eight hours, were completed between four and 11 hours past the required monitoring schedule.

A registered practical nurse stated that after an unwitnessed fall they were to complete clinical monitoring records in Point Click Care (PCC) and should follow the appropriate timing for the monitoring to be accurate.

The acting Administrator acknowledged the importance of completing the clinical monitoring as close to the established schedule as possible after an unwitnessed fall.

Failure to complete the clinical monitoring records as required may have resulted in staff not identifying complications from an unwitnessed fall, if the resident had sustained a head injury.

Sources: resident's clinical records, Fall Prevention and Management Program (RC-15-01-01, March 2023); interviews with Administrator and other staff. [720920]

WRITTEN NOTIFICATION: Records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee had failed to ensure that a resident's written record was kept up to date at all times,

specifically regarding fall prevention interventions.

Rationale and Summary
A resident, with a history of falls prior to admission, experienced multiple unwitnessed falls.

Three separate post fall assessments documented that a fall prevention device would prevent further potential falls; however, the assessment did not indicate whether that intervention was put in place. No progress notes were identified documenting whether that device was put in place as fall prevention intervention, details on how it would be used, or when it was implemented.

Two progress notes mentioned a different device that was typically used as a fall prevention intervention but did not contain further information regarding key details on its use or when it was implemented. A review of the post fall assessments did not identify documentation on the need or use of that device. No documentation in the resident's plan of care specified that either devices were being utilized as falls prevention interventions, including information on the specific type, how they would be used and/or when the interventions were initiated.

Two RPNs and two personal support workers (PSW) had different responses when asked about the use of those devices, including the type, location and number that were to be used as fall prevention. The Falls Lead was unaware that either device were being used for the resident and said that any interventions would have been added to the resident's care plan. They also explained that fall prevention interventions would have been monitored by PSWs and documented in Point of Care (POC); however, no such monitoring or documentation existed for either device.

The acting Administrator acknowledged that they were unclear if those devices were used as fall prevention interventions and that they expected the resident's care plan would have been updated with that information as per their typical practice.

Failure to keep a resident's written record up to date regarding falls prevention interventions may have resulted in needed interventions not being utilized as intended.

Sources: resident's clinical records, investigation notes; interviews with the acting Administrator and other staff. [720920]