Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: December 5, 2023	
Inspection Number: 2023-1126-0007	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kingston, Kingston	
Lead Inspector Lisa Kluke (000725)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on November 29 and 30, 2023

The following intake was inspected:

- Intake: #00101572 was related to a fall resulting in a significant change in condition of a resident.

A Training Specialist was present on site as an observer during this inspection.

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: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care related to falls prevention, was provided to a resident as specified in their plan.

Rationale and Summary:
On a specified date, the licensee submitted a Critical Incident Report (CIR) to the Director regarding a resident having fallen that resulted in a significant change in condition. This resident was attempting to self-transfer and fell to the floor that caused an injury.

The resident's current plan of care related to falls prevention required the nursing staff to ensure that they implement a specified falls prevention intervention for the resident. This falls prevention intervention will alert nursing staff when the resident attempts to get up from a chair which will provide nursing staff time to attend to the resident for assistance to potentially prevent falls. On a specified date two weeks later, the resident was observed seated in their wheelchair at their bedside. It was noted that the resident did not have this falls prevention intervention applied. Two

specified Personal Support Workers (PSW) who cared for the resident that day indicated the resident should always have this falls prevention intervention when they are seated in their wheelchair and one of the PSW's then also noted the resident's falls prevention intervention was not applied to the resident as required.

By not implementing this falls prevention intervention to the resident when they are seated in their wheelchair, prevented notification to nursing staff when the resident is attempting to self-transfer and increases their risk of falls.

Sources: A resident's health care records were reviewed, observation of this resident and interviews with nursing staff. [000725]