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 7, 2020	2020_790730_0012	010888-20	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Port Stanley
4551 East Road PORT STANLEY ON N5L 1J6

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

CHRISTINA LEGOUFFE (730)

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): June 29, 30, July 2, and 6, 2020, as an offsite inspection.

The purpose of this inspection was to inspect the following intake:
- Critical Incident (CI) 2669-000003-20/ Log #010888-20 related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care, and a Registered Nurse (RN).

The inspector also reviewed clinical records and specific policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the licensee was required to ensure that the strategy was complied with.

In accordance with O. Reg 79/10 s. 48 (1) 1, and in reference to O. Reg. 79/10 s. 49 (1) the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's "Falls Prevention and Management" strategy and "Post Fall Clinical Pathway" (#RC-15-01-01, updated December 2019), which required staff to use a mechanical lift to get a resident up after a fall, unless the resident was able to get up independently, or was being transferred to hospital by ambulance.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) on a specified date, related to a fall with hospital transfer for resident #001, which resulted in an injury. The CIS report stated that after the resident fell they were assisted to a chair by three staff members. When staff assisted the resident off the floor, they were able to bend their knees and was placed in a chair by staff. The report stated that the resident complained of pain and staff brought the resident's mobility device to them, but they were unable to stand. Staff manually lifted the resident and returned them to their room. The report later stated that staff were educated on the home's falls policy regarding how to get a resident off the floor following a fall.

Review of the progress notes in Point Click Care (PCC), showed a note which stated that resident #001 fell. The resident was assisted to a chair by three staff. The resident was

able to bed their knees to assist.

During an interview, Registered Nurse (RN) #101, said that if a resident fell, they were expected to do a vital sign and head to toe assessment to see if it was safe to get them up off the floor. They said a resident could either get up independently or if staff needed to assist them, it was the home's policy that they used a lift. RN #101 said that they were in the room, on a specified date, when a Personal Support Worker (PSW) brought resident #001 in and the resident fell. The RN said that they were going to direct the other two staff assisting the resident to go to get a lift, however, the staff had already manually lifted the resident off the floor. They said that they should have used a lift to get the resident up off the floor.

During an interview, Administrator and Director of Care #100, said that they expected that if a resident was unable to get up independently that at least two staff would use a mechanical lift to get the resident off the ground. They said that when resident #001 fell, on a specified date, that staff manually lifted the resident off the ground. They said that this was not in accordance to the home's policy and that training was done with staff in the moment.

The license has failed to comply with the home's strategy for Fall's Prevention and Management, when resident #001 fell. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 9th day of July, 2020

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

Original report signed by the inspector.