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

**North District**
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

# Original Public Report

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|---|---|
| **Report Issue Date:** July 31, 2023 | |
| **Inspection Number:** 2023-1549-0004 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** Corporation of the County of Simcoe | |
| **Long Term Care Home and City:** Georgian Manor Home for the Aged, Penetanguishene | |
| **Lead Inspector**<br>Justin McAuliffe (000698) | **Inspector Digital Signature**<br>Justin Christopher Mcauliffe<br>Digitally signed by Justin Christopher Mcauliffe<br>Date: 2023.07.31 09:42:13 -04'00' |
| **Additional Inspector(s)**<br>Charlotte Scott (000695)<br>Michelle Berardi (Training Specialist) was also present for this inspection | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 18 & 19, 2023

The following intakes were inspected:

- One intake related to an incident of physical abuse of a resident by another resident; and
- One intake related to an incident of a fall of a resident resulting in injury.

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

Infection Prevention and Control
Responsive Behaviours
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 (2)

The licensee failed to ensure that when a resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Specifically, the home failed to ensure that the post fall assessments were completed in their entirety, including the triggered user defined assessments (UDA) after the resident fell.

**Rationale and Summary**
A resident fell, which initiated the homes post fall assessment protocol. The homes post fall assessment tool triggered the following UDA's which were not completed: Post Fall Huddle, Pain Assessment Comprehensive, Fall Risk Assessment, and Skin Assessment. In interviews with the Registered Nurse and the Director of Care, it was noted that the post fall assessments should have been completed in their entirety, including the triggered UDA's by the post fall assessment tool.

The failure to ensure that the post fall assessments were completed in their entirety, resulted in low risk to the resident at the time of the incident.

**Sources:** The resident's healthcare records; progress notes; the home's policy titled "Falls Management Program" effective date September, 2019; risk management triggered UDA's; risk management post fall assessment; interviews with the Registered Nurse and the Director of Care. [000698]