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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2021	2021_857129_0009	000166-21, 015540-21, 017095-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

Gilmore Lodge
50 Gilmore Road Fort Erie ON L2A 2M1

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

PHYLLIS HILTZ-BONTJE (129)

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): November 5, 8, 9, 10, 15, 16, 17, 18, 19, 2021.

The following intakes related to falls were inspected:
015540-21
017095-21
000166-21

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Nurses, Resident Assessment Instrument Coordinator, Director of Resident Care and the Administrator.

During this inspection the Inspector observed a resident and their environment, reviewed electronic clinical records, reviewed the Licensee's Falls Prevention Program Policy and the Post Fall Assessment policy as well as toured 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)
1 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plans of care for three residents were based on

an interdisciplinary falls risk assessment.

i) The licensee failed to ensure a resident's plan of care was based on an interdisciplinary assessment of their risk for falls.

Nursing staff completed the falls risk assessment process in 2021, which indicated the resident was at high risk for falls when six generic conditions that place the resident at risk for falls were selected.

After completing the falls risk assessment process, the resident experienced a fall which resulted in the resident sustaining multiple injuries.

The Director of Resident Care (DRC) and registered staff #104 explained the licensee's policy requirements for completing a falls risk assessment process and at the time it was noted that the Licensee's policy directed registered staff were to complete the falls risk assessment process. Following a review of the falls risk assessment process that had been completed for this resident, they confirmed that no other disciplines had participated in the fall risk assessment process.
This resident was at potential risk of harm when staff did not complete an interdisciplinary falls risk assessment.

Sources: the resident’s clinical progress notes, electronic assessment records, the Licensee's policy "Falls Prevention Program" and interviews with staff #104 and the DRC.

ii) The licensee failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of their risk for falls.

Nursing staff completed a falls risk assessment process in 2021, which indicated the resident was at high risk for falls when eight generic conditions that place the resident at risk for falls were selected.

Following completion of the falls risk assessment, the resident experienced a fall, which resulted in the resident sustaining multiple injuries.

The DRC and registered staff #104 explained the licensee's policy requirements for completing a falls risk assessment process and at the time it was noted that the policy directed that registered staff are to complete the falls risk assessment process.

A review of the resident’s clinical record identified that there was no evidence in the clinical record that other disciplines participated in the falls risk assessment.

This resident was at potential risk of harm when staff failed to complete an interdisciplinary falls risk assessment.

Sources: the resident’s clinical progress notes, electronic assessment records, the Licensee's policy "Falls Prevention Program" and interviews with staff #104 and the DRC.

iii) The licensee failed to ensure that a resident’s plan of care was based on an interdisciplinary assessment of their risk for falls.

Over a two-day period in 2020, nursing staff completed a falls risk assessment process which indicated the resident was at low risk for falls when four generic conditions that placed the resident at risk for falls were selected. Although the "RNAO: Comprehensive Falls Risk Assessment Order Set" indicated that staff who completed the document identified "they wanted to initiate a referral to the Physiotherapist", a review of clinical progress notes and the assessment section of the electronic clinical record did not provide evidence that the Physiotherapist had participated in the falls risk assessment.

Following completion of the falls risk assessment the resident experienced a fall that resulted in the resident sustaining multiple injuries.

The DRC and registered staff #104 explained the licensee's policy requirements for completing a falls risk assessment process and at the time it was noted that the policy directed that registered staff were to complete the falls risk assessment process.

A review of the resident’s clinical record identified there was no evidence in the clinical record that other disciplines participated in the falls risk assessment process.
This resident was at potential risk of harm when staff failed to complete an interdisciplinary falls risk assessment.

Sources: the resident’s clinical progress notes, electronic assessment records, Licensee's policy "Falls Prevention Program" and interviews with staff #104 and the DRC. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring a plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including the risk of falls, to be implemented voluntarily.

Issued on this 2nd day of December, 2021

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

Original report signed by the inspector.