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

London District
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Original Public Report

Report Issue Date: November 29, 2023	
Inspection Number: 2023-1382-0003	
Inspection Type: Complaint Critical Incident	
Licensee: S & R Nursing Homes Ltd.	
Long Term Care Home and City: Heron Terrace Long Term Care Community, Windsor	
Lead Inspector Julie D'Alessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.11.30 13:00:10 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15, 20, 21, 27, and 28, 2023

The following intake(s) were inspected:

- Intake: #00092395/CI #2898-000013-23 related to improper/Incompetent treatment
- Intake: #00095180/CI#2898-000015-23 and Intake: #00095357/Complaint related to alleged neglect and falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Use of Equipment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Introduction:
The licensee failed to ensure that staff used equipment in the home in accordance with the manufacturers' instructions.

Summary and Rationale:
A Critical Incident (CI) was submitted to the Ministry of Long-Term Care indicating that a resident had an incident while staff were using equipment in the home. The incident led to a change in condition of the resident.

A review of the manufacturers' instructions for the equipment was reviewed and had clear instructions for use.

During separate interviews with staff members, they stated that the equipment was not used properly. The Manager of Resident Care also acknowledged that the equipment was not used in accordance with the manufacturers' instructions.

Sources: CI, the manufacturers' guide for the equipment, as well as staff interviews. [739]

WRITTEN NOTIFICATION: Fall Prevention and Management Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Introduction:
The licensee failed to ensure that the fall prevention and management program was complied with when a resident had fallen.

Summary and Rationale:
Ontario Regulation 246/22 s. 53 (1) 1. states that every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.
Ontario Regulation 246/22 s.11 (1) (b) states that where this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, that it is complied with.

A CI was submitted to the Ministry of Long-Term Care indicating that a resident had fallen.

The home's Fall Prevention and Management Program was reviewed and outlined the requirements that were to have been completed post-fall.

A review of the resident's clinical chart in Point Click Care (PCC) did not include several of the post-fall program requirements.

During interviews with staff, including a physician, they indicated that several of the post-fall program requirements were not completed.

During an interview with the Administrator they acknowledged that the home's fall prevention and management program had not been followed when the resident had fallen.

Sources: CI, the home's fall prevention and management program, the resident's clinical chart, as well as staff and physician interviews.
[739]

WRITTEN NOTIFICATION: Post-Fall Assessment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for

falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

Introduction:
The licensee failed to ensure that when a resident had fallen, the resident was assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

Summary and Rationale:
A CI was submitted to the Ministry of Long-Term Care indicating that a resident had fallen.

Record review of the resident's clinical chart in PCC had not included an assessment of the resident post-fall.

During an interview with the Administrator, they acknowledged that a post-fall assessment was not completed and should have been.

Sources: CI, the resident's clinical chart, and interview with the Administrator. [739]

WRITTEN NOTIFICATION: Skin and Wound Assessment

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a

clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

Introduction:
The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound.

Summary and Rationale:
A progress note in PCC indicated that the resident had an area of altered skin integrity. Upon further review of the resident's clinical chart there was no documentation that a skin assessment had been completed.

During an interview with the Administrator, they stated in part that, the area of altered skin integrity was not assessed using a clinically appropriate assessment instrument designed specifically for skin and wound.

Sources: The resident's progress notes and interview with the Administrator. [739]

WRITTEN NOTIFICATION: Resident Record

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274 (b) the resident's written record is kept up to date at all times.

Introduction:
The licensee failed to ensure that a resident's record was kept up to date after they had fallen.

Summary and Rationale:
A CI was submitted to the Ministry of Long-Term Care indicating that a resident had fallen.

Record review of the resident's clinical chart in PCC did not contain documentation of the fall.

During an interview with the Administrator, they acknowledged that the fall was not documented in the resident's clinical chart in PCC and should have been.

Sources: CI, resident's clinical chart, and interview with the Administrator.
[739]