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

Central West District
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Original Public Report

Report Issue Date: July 23, 2024	
Inspection Number: 2024-1401-0004	
Inspection Type: Critical Incident	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener	
Lead Inspector Mark Molina (000684)	**Inspector Digital Signature** Mark Molina Digitally signed by Mark Molina Date: 2024.07.25 11:02:28 -04'00'
Additional Inspector(s) Jasneet Ahuja (000865)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, 2024

The following intake(s) were inspected:

- Intake: #00120098 - [IL-0128115-AH/CI 2917-000037-24] - re: falls prevention and management
- Intake: #00117961 - [IL-0127080-AH/CI 2917-000028-24] - Unexpected death of resident

The following intake was completed in this inspection:

- Intake: #00113313 - [CI 2917-000016-24] - re: falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from physical abuse by a Personal Support Worker (PSW).

O. Reg.246/22, defines "physical abuse" as: (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
Physical contact between a PSW and a resident caused the resident to lose balance resulting in a fall with a fracture.

A Registered Nurse (RN) stated that through analysis of the incident, had the PSW not made physical contact with the resident, it could have prevented the resident from falling.

Manager of Resident Care stated that this incident meets the definition of physical abuse.

Failure to protect the resident from physical abuse caused the resident to sustain an injury.

Sources: Observation of Video evidence, resident clinical records, and interviews with the Manager of Resident Care and RN.
[000865]

WRITTEN NOTIFICATION: Required Programs

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.

The licensee has failed to ensure that the Personal Support Worker (PSW) remained with a resident after they had a fall.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the risk of injury.

Specifically, the home did not comply with the policy titled "Fall Prevention and Management Program" last revised May 18, 2022.

Rationale and Summary
The home's policy states when a resident falls, the staff should remain with the resident and call for assistance.

A resident had a witnessed fall in the dining room. After the resident's fall, the PSW spoke with the dietary staff and then left the dining room without informing the resident that they would return. The dietary staff observed the resident from behind the servery and also walked away, leaving the resident by themselves in the dining room.

Manager of Resident Care stated that, according to the home's policy, the PSW should not have left the resident unattended after the fall.

The video evidence revealed that both the PSW and the dietary staff left the resident unattended on the floor following the fall.

Sources: Observation of Video evidence, Fall Prevention and Management Program - RCM 10-02-01, last revised May 18, 2022, resident clinical records, and interviews with the Manager of Resident Care and RN.

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WRITTEN NOTIFICATION: Emergency Plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The licensee has failed to ensure that code blue was paged out to alert team members about a choking incident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have an emergency plan for dealing with medical emergencies.

Specifically, the licensee did not comply with the home's policy titled "Code Blue Medical Emergency", which stated that the overhead page is to be used to call out code blue to alert team members.

Rationale and Summary
As per the home's policy titled "Code Blue Medical Emergency," the first team member arriving on the scene will call out code blue, and one team member was to be delegated to complete the overhead page.

A Personal Support Worker (PSW) witnessed a resident have a medical emergency and alerted Registered Nurse (RN) of the incident. The RN began to provide interventions for the incident and also called an RN Supervisor for assistance. The overhead paging system was not used to call code blue, to alert other team members in the home of the medical emergency.

Manager of Resident Care (MoRC) stated that code blue should have been paged at

the time of the incident.

By failing to comply with the home's code blue policy, other team members on other home areas were not informed of the emergency and were unable to respond and provide assistance if required.

Sources: Resident clinical records, Interviews with MoRC and other staff, Home's policy titled "Code Blue Medical Emergency" last revised November 23, 2023 [000684]