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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: April 24, 2024
Inspection Number: 2024-1016-0002
Inspection Type: Complaint
Licensee: CVH (No. 2) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Maitland Manor, Goderich

Lead Inspector	**Inspector Digital Signature**
Megan Brodhagen (000738)	Megan Brodhagen Digitally signed by Megan Brodhagen Date: 2024.04.25 08:20:39 -04'00'

Additional Inspector(s)
Emma Perin (000869) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 21 - 22, 25 - 27 and April 2 - 3, 2024.

The following intake was inspected in this Complaint inspection:

- Intake: #00110343 was related to falls prevention and management

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

Infection Prevention and Control
Reporting and Complaints
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 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including monitoring of a resident post-fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the home's Falls Prevention and Management program was complied with.

As per the home's Falls Prevention and Management Program, Policy Number RC-15-01-01, last reviewed March 2023, if a resident hits their head or is suspected of hitting head (e.g., unwitnessed fall), then a Clinical Monitoring Record must be completed for the resident for 72-hours.

Rationale and Summary

A resident had an unwitnessed fall and was sent to hospital. The resident returned

to the home within the 72-hour timeframe to complete the Clinical Monitoring Record. Upon return, a Registered Practical Nurse (RPN) completed the Clinical Monitoring Record check for the current time post-fall. There were no further checks completed on the resident, leaving seven checks blank.

The resident had co-existing factors that would require additional monitoring such as being on an anticoagulant.

The Falls Lead stated that registered staff should have completed the entire Clinical Monitoring Record assessment for the 72-hours post-fall when the resident returned from hospital.

The resident was placed at risk of harm when they were not monitored post-fall.

Sources: A resident's Clinical records, Falls Prevention and Management Program; Policy Number RC-15-01-01 (last reviewed March 2023), Interviews with staff. [000738]