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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2020	2020_788721_0032	009443-20, 016473-20	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Anson Place Care Centre
85 Main Street North Hagersville ON N0A 1H0

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

MEAGAN MCGREGOR (721)

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 3, 4, 5, 6 and 9, 2020.

The following Critical Incident System (CIS) intakes were inspected during this CIS inspection related to falls prevention:
Log #009443-20, CIS #2786-000011-20; and
Log #016473-20, CIS #2786-000013-20.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Administrator, the Director of Care (DOC), a Registered Nurse (RN), two Personal Care Aides (PCAs) and residents.

The Inspector also observed staff interactions with residents, the care being provided to residents and falls prevention and management practices in the home; and reviewed clinical records and plans of care for the identified residents, the home's documentation related to the incidents and policies and procedures related the home's falls prevention program.

This inspection was conducted concurrently with Complaint Inspection #2020_788721_0033.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

A resident fell and was immediately transferred to hospital for assessment and admitted related to an injury sustained from the fall.

There was no post-fall assessment documented when this resident fell. An RN confirmed that no post-fall assessment was completed for this resident when they fell.

The DOC acknowledged there was no post-fall assessment documented for this resident related to the fall and said they would expect a post-fall assessment to be completed anytime a resident has a fall, including falls where the resident is immediately transferred to hospital.

Sources: Falls Prevention Program policy; residents progress notes and post-fall assessments; and interviews with an RN, the DOC and other staff. [s. 49. (2)]

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.