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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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 31, 2023

Inspection Number: 2023-1579-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Corporation of the County of Grey

Long Term Care Home and City: Rockwood Terrace Home for the Aged, Durham

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.06.06 09:26:37 -04'00'

Additional Inspector(s)
Jessica Bertrand (722374)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 10-12, 15-19, 2023
The inspection occurred offsite on the following date(s): May 18, 2023

The following intake(s) were inspected:
- Intake #00017826 and Intake #00018261 -related to improper care of a resident
- Intake #00022288 - concerns regarding the plan of care of a resident

The following intake(s) were completed in this inspection:
- Intake #00005594 -related to a fall of a resident resulting in injury

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Medication Management

Food, Nutrition and Hydration
Infection Prevention and Control
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)

The licensee has failed to comply with the fall prevention and management program's monitoring of residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure the falls prevention and management program, at a minimum, provided strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with the policy "Head Injury Routine" revised January 2021, which is captured in their falls prevention and management program. The policy directs staff to initiate a Head Injury Routine (HIR) when a resident has an unwitnessed fall.

Rationale and Summary

A resident was found on the floor in the hallway. A Registered Practical Nurse (RPN) was aware the resident had an unwitnessed fall, however, did not initiate a HIR to monitor the resident, or complete any other documentation to indicate the resident had fallen.

The resident presented with a new skin alteration the following day. The Director of Care (DOC) indicated that a HIR should have been initiated for the resident.

By not initiating HIR, there was risk that the resident could have had an unidentified head injury.

Sources: resident progress notes, skin and wound assessment; Homes investigation notes; Head Injury Routine Policy; Inspectors interviews with staff.

[741126]

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall and a post-fall assessment was not completed.

The resident presented with a new skin alteration the following day with an unknown cause. The Registered Practical Nurse (RPN) acknowledged that they should have completed a post-fall assessment on the resident.

By not completing a post-fall assessment the resident was at risk of presenting with injuries and not receiving care for these injuries.

Sources: resident progress notes, skin and wound assessment; Homes investigation notes; Falls prevention and management policy; Inspectors interviews with staff.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, the developed strategies were implemented to respond to the resident's behaviours.

Rationale and Summary

When care was being provided to a resident by three Personal Support Workers (PSWs), the resident was demonstrating responsive behaviours. The resident's care plan specified a strategy to implement when the resident was exhibiting responsive behaviours. The three PSWs did not implement this

strategy and continued to provide the resident care.

Days later, the resident presented with a new skin alteration and indicated that staff had hurt them in the day's prior. The three PSWs acknowledged that they should have used the strategy that was specified in the resident's care plan.

By not implementing the strategies developed for managing the resident's responsive behaviours, there was a risk to the resident's safety as the resident could have hurt themselves or others.

Sources: resident progress notes, care plan, skin and wound assessment; Homes investigation notes; Homes Interviews with staff; Staff statements; Responsive Behaviours Policy; Inspector's interviews with staff.

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