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: May 3, 2024
Inspection Number: 2024-1258-0002
Inspection Type: Critical Incident
Licensee: Shanti Enterprises Limited
Long Term Care Home and City: Royal Terrace, Palmerston

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.05.03 13:53:58 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11 - 12, and 16, 2024

The following intake(s) were inspected:

- Intake: #00110634 - 2767-000006-24 Fall of resident resulting in injury

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, related to falls risk and management.

A resident was assessed by the physiotherapist as at high risk for falls.

The home's staff assessed the resident as a low risk for falls.

The resident had a fall and sustained an injury.

Fall committee minutes did not include documentation of collaboration related to the resident's fall prevention management or recommendations for strategies to prevent further falls.

Failure to ensure collaboration between staff and others so that the resident's assessments were integrated, consistent and complemented each other may have

impacted the homes ability to determine appropriate fall prevention strategies for the resident.

Sources: plan of care, fall risk assessments, physiotherapy assessment, fall committee minutes. Interviews with DOC and physiotherapist.

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WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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 failed to comply with their fall prevention program related to implementation of strategies to reduce or mitigate falls and monitoring of residents post fall.

In accordance with O. Reg. 246/22 s. 11 (b) post fall the licensee was required to complete a thorough intervention assessment of the resident, including a Head Injury Routine if a head injury was suspected; as well they were to update the resident's plan of care with interventions which reflected the needs of the resident to prevent further falls or prevent injury from falls.

Specifically, staff did not comply the policy "Fall Risk Management", dated January 26, 2024, which was included in their Fall Prevention and Management Program.

A) A resident sustained an unwitnessed fall.

The plan of care was not updated with additional interventions to prevent further falls or prevent injury from falls.

The resident later again fell and sustained an injury.

The DOC and RN acknowledged the resident's plan of care had not been updated with new fall prevention strategies, following the resident's initial fall and it should have been.

Not updating the resident's plan of care post fall with additional fall prevention strategies was a missed opportunity to potentially prevent further falls or injuries from falls.

B) In accordance with O. Reg. 246/22 s. 11 (b) the licensee was required to ensure the monitoring of residents for a head injury post fall as appropriate, including vital signs check, pupil reaction and level of consciousness at intervals identified over a 48 hour period.

Specifically, staff did not comply with the policy "Head Injury Routine", dated January 6, 2024, which was included in the licensee's which was included in their Fall Prevention and Management Program.

A resident had an unwitnessed fall with injury.

A head injury routine (HIR) was initiated but not completed in its entirety at the prescribed intervals. On four instances, staff recorded that the resident was sleeping. There was no progress note documentation of rationale as to why a HIR could not be completed.

RN #103 said the resident should have been wakened and a HIR completed.

The DOC stated that staff should have wakened the resident to document a head injury routine or they should have documented in the progress notes why the resident was not wakened.

Failure to complete monitoring of a resident post fall, including head injury routine as required, may inhibit the homes ability to intervene with appropriate interventions in a timely manner if required.

Sources: progress notes, care plan, head injury routine, Policy: Fall Risk Management, section 05-00-01, January 26, 2024, Policy: Assessment of a head injury, section: 07-01-08, revised January 3, 2024, policy: Head injury routine, section 07-01-07, January 6, 2024, interviews with DOC and RN #103

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