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

North District
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Original Public Report

Report Issue Date: October 30th, 2023	
Inspection Number: 2023-1276-0002	
Inspection Type: Critical Incident	
Licensee: Sioux Lookout Meno-Ya-Win Health Centre	
Long Term Care Home and City: William A. "Bill" George Extended Care Facility, Sioux Lookout	
Lead Inspector Justin McAuliffe (000698)	**Inspector Digital Signature** Justin Christopher Mcauliffe Digitally signed by Justin Christopher Mcauliffe Date: 2023.11.01 15:45:34 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23rd to 25th 2023

The following intake(s) were inspected:

- An intake related to the fall of a resident resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead designated under O. Regulation 246/22 s. 102 (15) 1, worked in the position, on site at the home, for the required amount of time. Specifically, in a home with a licensed bed capacity of 69 beds or fewer, the IPAC lead should be present in the home at minimum 17.5 hours per week.

Rationale and Summary
At the time of the inspection, it was observed that the designated IPAC lead, was present in the home for approximately two hours. An interview with the IPAC lead indicated they were based out of the hospital and that they spent most of their time there. The IPAC Lead acknowledged that they were not in the home for the required 17.5 weekly hours. An interview with the Patient Care Manager also confirmed that the IPAC Lead was not working the minimum required hours of 17.5 per week in the home.

There was low risk to residents when the licensee failed to ensure the IPAC lead was on site, at the home, for the required hours per week.

Sources: Observations; Interviews with IPAC lead and Patient Care Manager. [000698]

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7)

The licensee failed to ensure that while a resident was restrained, that the restraint application, removal, release and reposition was documented in its entirety. Specifically, the home failed to ensure that on several days, that point of care charting was completed throughout the entire day with respect to restraint application, removal, release and reposition.

Rationale and Summary

A resident had a fall with injury. Following the incident, a physical device was implemented as a safety intervention. Once implemented, there was to be documentation every time the restraint was applied, removed, and released; as well as when the resident was repositioned, assessed, reassessed, and monitored, including the resident's response. However, after review of the point of care charting; staff failed to document for long periods of time across several different days. Interviews with the Extended Care Coordinator and Patient Care Manager both indicated that all application, removal, and release/reposition of the restraint should be documented in its entirety.

The failure to ensure that the documentation was completed in its entirety, resulted in low risk to the resident at the time of the incident.

Sources: Resident health care records; progress notes; point of care notes; interviews with Extended Care Coordinator and Patient Care Manager. [000698]