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

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Original Public Report

Report Issue Date: January 23, 2023
Inspection Number: 2023-1447-0004
Inspection Type: Critical Incident System
Licensee: AXR Operating (National) LP, by its general partners
Long Term Care Home and City: McGarrell Place, London

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2023.01.26 13:29:54 -05'00'

Additional Inspector(s) NA

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 17, 2023
January 18, 2023

The following intake(s) were inspected:
- Intake: #00016438/Critical Incident #2964-000069-22 related to the Fall Prevention Program
- Intake: #00018366/Critical Incident #2964-000004-23 related to the Fall Prevention Program

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

- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to fall prevention and management strategies.

Rationale and Summary:
The plan of care for the resident identified they were screened for fall risk. Post fall assessments and progress notes for the resident indicated the use of multiple specific fall prevention strategies over the course of several months.

The Director of Care (DOC) verified progress notes identified a new specific strategy to mitigate potential injury during falls and was not added to the care plan. The DOC stated there were progress notes and post fall assessments that indicated other fall strategies were also in use. The DOC stated the strategies were not added as part of the tasks in Point Click Care and these specific interventions were not included as part of the Kardex for the Personal Support Workers. The DOC verified the plan of care was not revised when to use the specific fall strategies. The DOC stated there was no documentation to indicate who implemented the strategies because the plan of care was not revised.

Nursing staff and others would not have a complete written plan of care that identified all fall strategies implemented to reduce the risk of falls and injury to the resident. The fall strategies were never added to the plan of care even though there was documentation in the progress notes and assessments that details their use for several months.

Sources: clinical record for the resident, and interviews with staff.
[563]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for the resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the Revera Post-Fall Management Procedure Index CARE5-010.05 and the Fall Prevention and Injury Reduction Program Policy Index CARE5- P10, both last revised March 31, 2022, was complied with as a part of the Falls Prevention and Management Program.

Rationale and Summary
The Revera Fall Prevention and Injury Reduction Post-Fall Management Procedure Index CARE5-010.05 last reviewed March 31, 2022, documented, "If a fall is un-witnessed or the Resident was witnessed hitting his/her head during the fall, the Head Injury Routine is initiated, and Neurovitals are monitored for 72 hours." The Revera Fall Prevention and Injury Reduction Fall Prevention and Injury Reduction Program Policy Index CARE5- P10 last reviewed March 31, 2022, documented the Head Injury Routine as a procedure.

Post Fall Assessment V2 were completed in Point Click Care for the resident and the Neurological Flowsheets had missing documentation on multiple dates at multiple times.

The Director of Care verified a Head Injury Routine was completed using the paper Neurological flowsheet. The DOC verified there was missing documented monitoring of the neurological status of the resident on multiple dates at multiple times. The DOC stated the neurological monitoring of the resident did not occur at the time specified as part of the neurological flowsheet before the resident's specific medical incident happened.

The neurological status of the resident was not monitored at the specific times required as part of the Neurological Flowsheet. There was no evidence of the assessment of the resident's neurological status before their specific medical incident to ensure they were neurologically stable.

Sources: review of the clinical record for the resident, relevant policies, and staff interview.
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