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

Ottawa District
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Original Public Report

Report Issue Date: October 26, 2023
Inspection Number: 2023-1482-0003
Inspection Type: Critical Incident
Licensee: Lennox and Addington County General Hospital Association
Long Term Care Home and City: Lennox and Addington County General Hospital, Napanee

Lead Inspector Patricia OBrien (000730)	**Inspector Digital Signature** Patricia E O'Brien Digitally signed by Patricia E O'Brien Date: 2023.10.31 20:36:39 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00096359 CI #7089-000005-23 - Fall of resident resulting in injury.

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

Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: NOT COMPLYING WITH POLICY OR PROCEDURE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

The licensee has failed to comply with the Lennox and Addington Falls Prevention Strategy and Management Program Policy.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that their written policy related to Falls Prevention Strategy and Management Program Policy is complied with.

Specifically, staff did not comply with Lennox and Addington Inpatient Falls Prevention Strategy and Management Program Policy by not ensuring that resident's fall resulting in being sent to hospital was reported to the Acting Director of Care (ADOC)

Rationale and Summary:
Lennox and Addington Inpatient Falls Prevention Strategy and Management Program Policy indicates that the Director of Care must be notified immediately after a fall that requires a transfer to hospital. In an interview with RPN registered staff were required to report a fall immediately to the DOC, when the resident is transferred to hospital.
Interview with Chief Nursing Officer (CNO) confirmed the DOC was away at the time of the fall and the CNO was ADOC at time of resident's fall. CNO confirmed that the registered staff did not report the incident at the time of the fall to the ADOC as per policy but reported it four days post fall.

Failing of registered staff to report resident fall to the ADOC does not allow the ADOC to follow up appropriately.

Sources: Record Review of Lennox and Addington Inpatient Falls Prevention Strategy and Management Program Policy, interview with RPN and CNO. [000730]

WRITTEN NOTIFICATION: LATE REPORTING OF CRITICAL INCIDENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was made aware when resident fell with injury and was transferred to hospital.

Rationale and Summary:
A critical incident report was submitted to the Director indicating that a resident had an unwitnessed fall resulting in injury requiring hospital assessment.

In a review of the CIR it was noted that it was first submitted to the Director on a specified date in September, four business days post fall.

During interview with RPN, they confirmed that the policy requires registered staff to report the incident immediately to the Director of Care (DOC). On September 28, 2023 the CNO further confirmed that the incident was not reported to her by the registered staff until a specific date in September 2023. CNO agreed that the CIS report was four days overdue.

Failing to ensure that the Director was informed of resident fall with injury does not allow the Director to follow up.

Sources: Critical Incident Report, Health Records, interview with RPN and CNO. [000730]