Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2021	2021_908642_0005	004211-21	Critical Incident System

Licensee/Titulaire de permis

North Shore Health Network
525 Causley Street P.O. Box 970 Blind River ON P0R 1B0

Long-Term Care Home/Foyer de soins de longue durée

North Shore Health Network - LTC Unit
525 Causley Street P.O. Box 970 Blind River ON P0R 1B0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 13-17, 2021.

The following intake was inspected during this Critical Incident System (CIS) inspection:

A Log, related to a residents fall which caused an injury.

A concurrent Service Area Office Initiated Inspection (SAOII), #2021_908642_0004, was conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO)/President, Long Term Care (LTC) Managers, Quality Lead and Coordinator, Maintenance Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Aid, Personal Support Workers (PSWs), Housekeeper, family members, and residents.

The Inspector also conducted a daily tour of the resident care areas, reviewed relevant resident records and policies, the Infection Prevention and Control (IPAC) practices were reviewed, and interviews and observed resident rooms, resident common areas, dining areas, reviewed recorded temperatures, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, “Just Clean Your Hands,” (JCYH) related to staff assisting residents with HH before and after meals.

Resident’s hands were not observed to be cleaned before or after meals.

The home's HH program did not include a process for staff to assist residents to clean their hands before and after a meal, snacks or activities.

The failure to have a hand hygiene program in place in accordance with evidence-based practices (EBPs) presented a minimal risk to residents.

Sources: Observations of residents at meals; Interviews with the Quality Lead and Coordinator; and other staff; the home’s policy Hand Hygiene, and “Just Clean Your Hands,” program resources. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, an with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was reviewed and revised after the resident's care needs changed.

A critical incident (CI) report was submitted which identified a resident had a fall, which resulted in the resident having an injury.

The resident's record identified that a fall intervention was in place. However, the resident's plan of care had not been updated when the falls intervention was implemented.

The Quality Lead and Coordinator stated that the specific intervention should have been added to the care plan when the resident started to have more frequent falls and their care needs changed, they were unclear why the intervention was not added immediately to the resident's care plan.

Sources: Resident's care plan and Post Fall Risk Assessment and Intervention documents, progress notes; the home's policy titled Fall Prevention and Management, interview with the Quality Lead and Coordinator, and other staff. [s. 6. (10) (b)]

Issued on this 8th day of October, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.