Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2018	2018_771734_0001	029779-17, 000293-18, 007482-18, 028358-18	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Coleman Care Centre
140 Cundles Road West BARRIE ON L4N 9X8

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

JADY NUGENT (734), MICHELLE BERARDI (679)

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): December 10 - 14, 2018.

The following intakes were inspected upon during this Critical Incident System inspection.
-Three intakes submitted to the Director for resident falls; and
-One intake submitted to the Director for an incident resulting in an injury to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Care (DNC), Resident Assessment Instrument Coordinator/Assistant Director of Nursing Care (RAI Coordinator/Assistant Director of Nursing Care), Kinesiologist, Registered Nurses (RNs), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector also observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records as well as relevant policies and procedures in relation to falls prevention management and personal support services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, the planned care for the resident.

A Critical Incident (CI) report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. Resident #004 had fallen and sustained an injury.

Inspector #734 observed resident #004 using a specific mobility device on two occasions. Inspector #734 reviewed the current electronic care plan which identified that resident #004 was to use a different mobility device. The care plan did not specify the mobility device the Inspector observed in use by resident #004.

Inspector #734 reviewed the care plan with PSW #115 and RN #100 to identify if the mobility device observed by the Inspector was outlined in the care plan. Both PSW #115 and RN #100 confirmed that the information set out in the care plan did not specify the use of the observed mobility device.

In an interview with the Director of Nursing Care, they confirmed that the care plan did not specify the use of the observed mobility device for resident #004, and that this information should have been in the care plan [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49(2)]

A Critical Incident (CI) report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. Resident #001 had fallen and sustained an injury.

Inspector #734 reviewed the resident's health care records, which identified that resident #001 did not have a completed post-fall assessment on the day of the fall. The first recorded post-fall assessment of resident #001 was two days post fall.

A review of the policy entitled "Fall Prevention and Management Program" identified that staff were to complete a post-fall assessment using the Falls Incident Report located in the current computerized software system. The policy further identified that staff were to complete a detailed progress note at the time of the fall and review the plan of care for current strategies.

In an interview with Resident Assessment Instrument Coordinator #119 they identified that the falls incident report was not completed on the day of the incident. Further to this, they confirmed that the home's policy was that the registered staff member attending the fall was responsible for completing the falls incident report/note at the time of the incident.

In an interview with the Director of Nursing Care it was also confirmed that there was no electronic record of a fall incident note on the date of the fall. [s. 49. (2)]

Issued on this 31st day of December, 2018

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

Original report signed by the inspector.