Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

# 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**

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## 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 |
|---|---|---|---|
| Aug 27, 2019 | 2019_745690_0022 | 006784-19 | 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

TRACY MUCHMAKER (690)

## 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): August 20-22, 2019.**

**The following intake was inspected upon during this Critical Incident System Inspection:**
**-One log, which was related to a critical incident report that the home submitted to the Director for a fall that resulted in a transfer to hospital.**

**Follow Up inspection 2019_745690_0021 was conducted concurrently during this Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Care (DNC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed health care records, internal investigation notes, as well as licensee policies, procedures and programs.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Director for a fall that resulted in a transfer to hospital and a significant change in health status. The CI report indicated that resident #001 had fallen on an identified date, and was complaining of pain. The resident was transferred to the hospital and was diagnosed with an identified injury. The CI report further indicated that the resident had two identified interventions in use.

During an observation of resident #001's room, Inspector #690 noted that there was only one of the two identified interventions were in use.

Inspector #690 reviewed resident #001's electronic care plan and identified that the resident was at risk for falls and staff were to have two identified interventions in use.

In separate interviews with Inspector #690, Personal Support Worker (PSW) #102 and PSW #103, indicated that resident #001 was at risk of falling and that they were to have one identified intervention in use. They further identified that they did not recall resident #001 ever having two identified interventions in use.

In an interview with Registered Practical Nurse (RPN) #104, they indicated that staff would utilize the care plan on Point Click Care (PCC) to find information on what falls prevention interventions were in place for each resident. RPN #104, indicated that resident #001 had an identified intervention in place. Together RPN #104 and Inspector #690 reviewed the resident's care plan and RPN #104 identified that the care plan indicated that there was to be two identified interventions in use and that care was not provided to resident #001 as indicated in the care plan and that it should have been.

In an interview with the Director of Nursing Care (DNC), they indicated that staff would utilize the care plan to find out what falls prevention interventions were in place for each resident and that resident #001 was to have two identified interventions in use according to the care plan. The DNC identified that the second identified intervention was to be implemented after the resident returned from the hospital. The DNC further indicated that staff did not provide care as specified in resident #001's plan of care and that they should have. [s. 6. (7)]

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**Issued on this 29th day of August, 2019**

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

**Original report signed by the inspector.**