Ontario

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

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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
Oct 8, 2020	2020_782736_0020	018491-20	Complaint

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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 28-October 2, 2020. Additional off site activites took place on October 5 and 6, 2020.

During the course of this inspection, the following log was inspected:
-one log, related to a complaint submitted to the Director related to falls prevention for a resident.

During the course of the inspection, the inspector(s) spoke with the General Manager, Co-Director of Nursing, Physician, Coroner, Kinesiologist, Registered Nurse(s) (RNs), Registered Practical Nurse(s)(RPNs), Personal Support Worker(s) (PSWs), Neighbourhood Coordinator, family members, and residents.

During the course of the inspection, the Inspector(s) conducted daily tours of the home areas, and observed the provisions of care, as well as reviewed resident health care records, staff files, licensee internal policies and procedures, staff meeting minutes, and Falls Prevention Committee Meeting minutes.

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

During the course of this inspection, Non-Compliances were issued.
1 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 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care provided clear direction to staff and others who provided direct care to the resident related to falls prevention.

The resident's care plan indicated that the resident was to have an intervention as a fall prevention measure. The care plan did not indicate where to place to the intervention in relation to the resident. The Registered Practical Nurse (RPN) was unsure of where to place the intervention for the resident, and indicated that the care plan was not specific.

Sources: resident's care plan, progress notes, observations of resident, interviews with

the RPN, and other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a resident's plan of care provided clear directions to staff and others who provided direct care to the resident related falls prevention.

The resident's care plan indicated that they required the use of an intervention as a falls prevention measure. The care plan did not specify where to place the intervention in relation to the resident. The Associate Director of Nursing (ADON) indicated that the plan of care did not indicate where the intervention should have been placed for the resident.

Sources: Resident's care plan; interviews with the ADON, as well as other staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff involved in a resident's care collaborated with each other in the assessment of the resident so that the physiotherapy and nursing assessments were integrated, consistent with and complemented each other.

The resident was assessed by the physiotherapist, which indicated that the resident was at risk for falls, however, the assessment failed to note that the resident had sustained multiple falls. In an interview with the ADON and the Kinesiologist, they indicated to the Inspector that the physiotherapist assessment should have been consistent with the nursing assessments that had been completed for the resident related to multiple falls.

Sources: resident's post fall assessments and physiotherapy assessment; interviews with the ADON and Kinesiologist, as well as other staff. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care provided to a resident was provided as specified in the plan related to their bed being in the a specific position.

Inspector #736 observed the resident, in bed, with the bed in an elevated position. The Personal Support Worker (PSW) indicated that the bed was not in the specified position, and it should have been as per the care plan.

Sources: resident's care plan, observation; interview with the PSW, and as well as other staff. [s. 6. (7)]

5. The licensee has failed to ensure that when the care set out in the plan was not effective for a resident, in relation to falls prevention, different approaches had been considered in the revision of the plan of care.

The resident's progress notes indicated that the resident had sustained a specific numbers of falls the month of their admission to Long Term Care, and another specific number of falls the month after their admission. The care plan indicated that the last falls prevention intervention was added five days after the resident's admission; there were no further interventions added or removed after that date. The resident sustained a number of falls, after the intervention had been added.

In an interview with the RPN and the ADON, they indicated that based on the number of falls resident #001 had sustained, the interventions were ineffective, and other interventions should have been considered.

Sources: resident's care plan and progress notes, post fall assessments; interviews with the RPN and the ADON and other staff, and Falls Committee Minutes. [s. 6. (11) (b)]

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 the plan of care provides clear direction to staff providing care, and to ensure that when the interventions are ineffective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 9th day of October, 2020

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

Original report signed by the inspector.