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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
May 13, 2019	2019_727695_0010	027044-18, 033317-18, 000111-19	Critical Incident System

Licensee/Titulaire de permis

Derbecker's Heritage House Limited
54 Eby Street St Jacobs ON N0B 2N0

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

Derbecker's Heritage House
54 Eby Street St. Jacobs ON N0B 2N0

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

FARAH_ KHAN (695)

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): May 7, 8, and 9, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Intake# 027044-18, related to a fall
Intake #000111-19, related to a fall
Intake #033317-18, related to a fall

The inspector also toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records and policies and procedures.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Falls Lead, and the Director of Care (DOC).

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. (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 the care set out in the plan of care related to falls prevention and management was provided to the resident as specified in the plan.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) stating that resident #002 had a fall and sustained a hip fracture on December 22, 2018. A record review showed that resident #002 had multiple falls in a six-month period in 2019.

The current plan of care for falls prevention was reviewed and it stated that resident #002 was on a toileting routine, with specific timings at which the resident was to be toileted.

Observations conducted on a specific date in 2019, showed that the resident was not toileted at the specific times within the plan of care.

In an interview with PSW #102, they acknowledged that they did not toilet the resident at the specified times.

The Falls Lead stated that the toileting routine for resident #002 was developed using a three-day voiding diary and monitoring the resident's activity. They said it was adjusted so that staff would intervene before the resident would attempt to get up on their own with the aim to prevent a fall. They confirmed the current toileting routine was what was identified in the resident's plan of care.

The licensee has failed to ensure that the care set out in the plan of care, specifically the toileting routine set out in the falls prevention interventions, was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of May, 2019

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

Original report signed by the inspector.