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 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2016	2016_200148_0015	008701-16	Critical Incident System

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET P.O. BOX 970 WINCHESTER ON K0C 2K0

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

AMANDA NIXON (148)

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 18, 2016

This inspection included Critical Incident Report #2674-000002-16.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Assistant Director of Care, Registered Nursing Staff and Personal Support Workers.

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	Legendé 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 was provided to resident #001, as specified in the plan, related to the use of bed rails.

Resident #001 required assistance with activities of daily living including mobility, positioning and personal hygiene. The resident's plan of care included that quarter rails are in place to aid with bed mobility.

During an interview with PSW #101, she described that on the morning of an identified date, she entered resident #001's bedroom to provide morning care. Resident #001 was in bed, and upon approach to the resident's bedside she pulled closed the privacy curtain from the left side of the bed near the left side rail to enclose the care area. PSW #101 then stood on the right side of the bed, to begin care. At this position, PSW #101 could not see the left side rail, due to the curtain position between the mattress and rail. PSW #101 describes that at a point during care she turned resident #001 onto the resident's left side, positioning the resident off center to the mattress and nearer to the left edge of the mattress. As PSW #101 continued to provide care the resident rolled off the left side of the bed. Interview with PSW #101 and the home's investigation indicate that the left bed rail was not engaged. The resident sustained injury.

On an identified date, resident #001 was not provided with bed rails as specified in the plan of care. [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 the ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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Issued on this 19th day of May, 2016

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

Original report signed by the inspector.