Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
November 2, 2010	2010_192_8521_02Nov112708	Critical Incident (H – 01519)

Licensee/Titulaire
The Elliot, 170 Metcalfe Street, Guelph, ON, N1E 4Y3

Long-Term Care Home/Foyer de soins de longue durée
The Elliott Home, 170 Metcalfe Street, Guelph, ON, N1E 4Y3

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

Debora Saville #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Registered Practical Nurse, Physiotherapist, and Personal Support Workers.

During the course of the inspection, the inspector reviewed the resident record, policies related to Fall Prevention and Pain Management.

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

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 6 (1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

A specified resident sustained multiple falls and increasing pain in the hip and knee resulting in transfer to hospital for assessment and was diagnosed with a fracture. Since returning from hospital the specified resident continued to sustain multiple falls. The progress notes contain examples of interventions that may have helped prevent further falls and improve comfort for this resident if communicated to the care team.

1. Documentation in the progress notes indicates the resident was to be on "hip precautions", including that the resident should not bend past 90 degrees, is to use a pillow between the knees when turning on the side, and is not to cross their legs." This information is not included on the plan of care for access by personal support workers.
2. Documentation in the progress notes indicates that the resident "requires verbal cueing for safe transfers", this information is not communicated clearly in the plan of care for all who provide direct care to the resident.
3. Documentation in the progress notes indicates that the resident is to be on a toileting routine and is not to be left unattended in the bathroom. The plan of care does not provide direction to staff on details related to the toileting routine required by the resident or that the resident should not to be left unattended in the bathroom.
4. Documentation in the progress notes indicates that the resident will show signs of restlessness when they have to go to the bathroom. There is no indication of this information being communicated on the plan of care for others who provide direct care to the resident.

The specified resident sustained seven additional falls during a defined time period.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. (10)

The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

Findings:

1. The specified resident's progress notes were reviewed for a defined period of time. There are frequent documented episodes of pain in and changes in mobility status. These changes did not result in reassessment and revision of the plan of care.

2. A physician was asked to see the designated resident related to pain in the knee, yet no plan of care was developed for the monitoring and evaluation of the pain experienced by the resident.

3. There was no evidence in the specified resident's clinical record of an assessment of the residents voiding pattern to determine an appropriate toileting schedule. There is recommendation in the progress notes that indicate the resident should be on a toileting routine, and should not be left unattended in the bathroom. The resident continues to attempt to self transfer to the bathroom and has experienced multiple falls.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Debora Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 31, 2011