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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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, 2019	2019_729615_0052	018960-19	Other

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove MISSISSAUGA ON L5H 2S6

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

Exeter Villa
155 John Street East EXETER ON N0M 1S1

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

HELENE DESABRAIS (615), AMBERLY COWPERTHWAITE (435)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): October 3 and 4, 2019.

The purpose of this inspection was to conduct a Service Area Office Inspector Initiated Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Director of Activation and Rehabilitation, a Registered Nurse, two Registered Practical Nurses, one Personal Support Worker, the Resident Council President and residents.

During the course of this inspection the inspector(s) conducted a tour of the home, observed a medication administration, a dining service, the provision of care, staff to resident interactions, reviewed relevant clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were documented; the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care.

During review of residents whom had fallen in the home on a specific date with injury and/or transfer to hospital, it was documented that a resident had sustained a fall resulting in an injury.

During review of a resident's care plan it directed staff under the focus "Risk for falls" to monitor the resident's devices when activated.

During review of the resident's progress notes in Point Click Care (PCC), it was documented that the resident had sustained a fall in their bedroom on on a specific date after the resident had been placed in their chair for a rest. The note continued to state, in part, that the staff member heard the device go off and upon investigation, the resident was found on the floor sustaining an injury.

During review of another progress note documented on a different date, it was noted that the resident was found on the floor by a Personal Support Worker (PSW) in another area of the home. There were no documented evidence that the resident's device was in place or went off when the resident was found in another area of the home.

During an interview with a Registered Nurse (RN), when asked if the devices was used for the resident, the RN stated yes and that they were in place. When asked whose responsibility it was to ensure that the devices were activated and in place, the RN stated that it was the PSW's responsibility to ensure the devices were activated when they were going into resident's rooms and putting the resident in their bed or chair. When asked where the provision of the devices put in place were documented, the RN stated that it would be on the PSW's Point of Care (POC). The Registered Practical Nurse (RPN), reviewed the resident's POC and stated that they did not see anything on POC for the documentation. When asked if every resident in the home that devices in place would have this provision of care documented, the RN stated in part that they implemented the intervention however, it was not documented.

Review of the home's devices' audit identified that 10 residents used the devices.

During an interview, the Director of Activation and Rehabilitation stated that PSW's place the deviceon the residents' beds and were to ensure they were working and stated that

they did not know if it was documented in PCC or if they monitored the devices.

During an interview, Director of Care, when asked if the device were in place, where the intervention would be documented by the PSW's if they were applying and ensuring that they were working and activated, DOC stated that they did not know if it was documented in the POC section on PCC, however PSW's did monitor. When asked if they would expect that the provision of device into a resident' s plan of care be documented, the DOC stated, yes and that it would need to be documented daily on every shift that it was in place and that it was working. The DOC continued to state that they would have this corrected.

The licensee had failed to ensure that 10 residents had the provision, the outcomes or the effectiveness of their devices documented. [s. 6. (9)]

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 following were documented; the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care, to be implemented voluntarily.

Issued on this 9th day of October, 2019

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

Original report signed by the inspector.