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 21, 2019	2019_727695_0027	014089-19, 016470-19	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Faith Manor Nursing Home
7900 Mclaughlin Road South BRAMPTON ON L6Y 5A7

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): October 1 and 2, 2019.

During the course of the inspection, the following Critical Incident intakes were inspected:
Intake #014089-19, CI #2745-000006-19, related to a fall with injury
Intake #016470-19, CI #2745-000008-19, related to a fall with injury

The Inspectors 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 resident, personal support workers (PSW), registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) RPN, the Director of Care (DOC), and the Administrator.

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the Falls prevention and management program, including interventions were documented.

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) stating that on a specific date in August 2019, resident #002 had a fall that resulted in an injury.

The written plan of care at the time stated that the resident was to have a specific intervention in place for falls prevention and management. The point of care documentation did not have a task for Personal Support Workers (PSWs) to apply the specific intervention or to check if it was working.

PSW #100 stated they heard a loud noise and immediately went to see that resident #002 was on the floor. They stated that the specified intervention was not functioning when they entered the room.

Registered Nurse (RN) #106 acknowledged that there was no documentation to support that the specified intervention was implemented and in working condition.

The licensee failed to ensure that any actions taken with respect to a resident under the Falls prevention and management program, specifically that the intervention was in working condition, was documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including interventions are documented., to be implemented voluntarily.

Issued on this 24th day of October, 2019

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

Original report signed by the inspector.