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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2013	2013_220111_0021	000038	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

FENELON COURT
44 WYCHWOOD CRESCENT, FENELON FALLS, ON, K0M-1N0

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

LYNDA BROWN (111), MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 13, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physiotherapist, Personal Support Worker (PSW), and the Resident.

During the course of the inspection, the inspector(s) observed the resident, reviewed the health record of the resident, and reviewed the homes policy on Falls Interventions Risk management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the Substitute Decision Maker(SDM) of Resident #1 was notified of falls to allow the substitute decision maker the opportunity to participate Resident #1's plan of care.

Review of the health record for Resident #1 indicated there was inconsistency in reporting of falls to the resident's SDM as the resident sustained multiple falls and the SDM was notified of only two of the falls.

There was inconsistency in reporting of falls to the resident's SDM from December 2012 to July 2013. [s. 6. (5)]

2. The licensee failed to ensure that when the resident was reassessed post fall, the resident's plan of care was reviewed and revised when the interventions were not effective to help mitigate further falls and that different approaches were considered.

Review of the plan of care for Resident #1 indicated the resident was a medium risk for falls despite falling multiple times during a three month period. There was no indication the resident's written plan of care was revised during that time period.[s. 6. (11) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a post fall assessment was completed for Resident #1 after each fall.

Review of the homes policy "Fall Intervention Risk Management (FIRM) Program-National policy" (LTC-N-75) (Revised March 2012) indicated:
The following assessments are to be done after each fall(The Nurse will complete)-
1. Post Fall Action Checklist.

A review of Resident#1 health record indicated the resident had multiple falls during a three month period.

Review of the post falls assessments for Resident #1 indicated only one FRAT (Falls Risk Assessment Tool) was completed and was scored at 5.0 (puts resident #1 in low risk category). [s. 49. (2)]

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Issued on this 16th day of December, 2013

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