Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 7, 2020	2020_683126_0002	023635-19	Critical Incident System

Licensee/Titulaire de permis

Genesis Gardens Inc.
1003 Limoges Road South Limoges ON K0A 2M0

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

Foyer St-Viateur Nursing Home
1003 Limoges Road South Limoges ON K0A 2M0

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

LINDA HARKINS (126)

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): February 5, 202

During the course of this inspection the following log was inspected;
Log # 023635-19 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), one Personal Support Worker (PSW), one Registered Practical Nurse (RPN) and one resident.

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 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 supervision while being toileted.

Resident #001 was admitted to the home in 2018. As per the plan of care, resident #001 required constant supervision while being toileted and was not to be left unattended.

A per a Critical Incident of 2019, resident #001 was sitting on the toilet in the tub-shower room and was briefly left unattended during toileting by Personal Support Worker (PSW) #102. The resident attempted to transfer self from toilet to the wheelchair and fell on floor. The fall resulted in a fracture.

On February 5, 2020, PSW #102 indicated that they were aware that resident #001 required constant supervision and should not have been left unattended. PSW #102, indicated that they went out of the tub-shower room because they had forgotten the resident incontinence product. PSW #102 indicated that when returning to the tub-shower room, resident #001 was observed to have fallen to the floor.

On February 5, 2020, Registered Practical Nurse #103, indicated that they were notified of the fall immediately when the resident was found on the floor. The resident was assessed and transferred to the bed in the bed room. Resident #001 was complaining of pain in the leg and was transferred to the hospital. RPN #103 indicated that PSW #102 was upfront informing them that the resident was left unattended and caused the fall.

The licensee has failed to ensure that the care related to toileting was provided to resident #001 which resulted in a fall that caused a fracture. [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 to ensure that the care set out in the plan of care is provided to resident as specified in the plan, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.