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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Sep 24, 2013	2013_128138_0035	O-000747-13	Critical Incident System

Licensee/Titulaire de permis

ARNPRIOR (THE) AND DISTRICT MEMORIAL HOSP.
350 John Street North, ARNPRIOR, ON, K7S-2P6

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

THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME
275 IDA STREET NORTH, ARNPRIOR, ON, K7S-3M7

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

PAULA MACDONALD (138)

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): September 18, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, and a Personal Care Worker.

During the course of the inspection, the inspector(s) reviewed Critical Incident Report, the home's internal incident documents, and a resident's health care record.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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. (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 failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan of care.

The Ministry of Health and Long Term Care received a Critical Incident Report that indicated Resident #1 had fallen on a date in August 2013 when two staff members left the resident unattended while s/he was on the toilet. The resident fell from the toilet and was later transferred to the hospital and diagnosed with an injury.

Long Term Care Homes Inspector #138 spoke with the home's Director of Care and Assistant Director of Care regarding the Critical Incident Report. Both the Director of Care and the Assistant Director of Care stated that Resident #1 was to have constant supervision while being toileted as per the resident's plan of care and that the resident had fallen from the toilet while the two staff members were outside the resident's washroom.

Long Term Care Homes Inspector #138 reviewed the home's internal incident documentation relating to Resident #1's fall. The home's Internal Incident Report stated that the resident was left on the bathroom toilet while staff stepped out thereby leaving the resident unattended and s/he fell. The Internal Incident Report further stated that a contributing factor to the resident's fall was negligence of staff.

An additional internal incident document stated that Resident #1 fell from toilet when s/he was left unattended as a result of not checking the kardex and not understanding care plan language.

The plan of care and kardex for the Resident #1 in place at the time of fall was reviewed and it was noted that the one of the interventions for toileting was a two person total assistance for the entire process.

Long Term Care Homes Inspector #138 spoke with a PSW (personal care worker) who was present when the resident fell off the toilet. The PSW stated that s/he was aware that the resident was required to have two staff members present at all times when being toileted. The PSW stated that s/he and the other personal support worker present were outside the resident bathroom when the resident was on the toilet and confirmed that the resident was not visible to either of the staff members. The PSW further stated that the resident fell off the toilet while both staff members were outside the resident's bathroom. [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 care for Resident #1 is provided according to the plan of care to prevent/minimize incidents of falls, to be implemented voluntarily.

Issued on this 24th day of September, 2013

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

Paula MacDonald RD