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 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
Nov 19, 2018	2018_624196_0029	002033-18, 025442-18	Critical Incident System

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Northwood Lodge
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

LAUREN TENHUNEN (196)

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): November 5 - 8, 2018.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- One regarding an incident of alleged staff to resident neglect; and
- One regarding a resident fall with injury.

Complaint inspection #2018_624196_0027 and Follow Up inspection #2018_624196_0028 were conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSWs) and Residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, home's internal investigation notes, and staff education records.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the Director, which outlined an incident of alleged staff to resident neglect, which had occurred in 2018. The report indicated that resident #011 had not been provided with their prescribed medical intervention which had been signed for.

Inspector #196 reviewed the home's investigation file which included evidence that resident #011's prescribed medical intervention was not provided despite it being signed off as given.

Inspector #196 reviewed the health care records for resident #011. The care plan identified an intervention which outlined the prescribed medical intervention and the associated times. The physician's order, dated on a specific date, that was current at the time of the incident, indicated the details of the medical intervention.

During an interview with the Administrator, they reported to the Inspector, that a complaint had been brought forward when it was identified that resident's prescribed medical intervention had not been given. In addition, this same complainant provided evidence which demonstrated that the prescribed medical intervention had not been administered. The Administrator acknowledged to the Inspector, that the care set out in the plan of care for resident #011 was not provided, on a specific date, when their prescribed medical intervention was not administered. [s. 6. (7)]

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.