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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2016	2016_243634_0016	024292-16, 023850-16	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

ADAM CANN (634)

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): August 22, 23, 24, 25, 29,30,31, September 1, and 2, 2016

The following intakes were completing concurrently within this inspection:

Complaint log # 024292-16, and # 023850-16 related to a fall

During the course of the inspection, the inspector(s) spoke with the Director Of Care, the Physiotherapist, two Personal Support Workers, and one Registered Nurse.

The inspector reviewed clinical records and plan of care for resident, pertinent policies and procedures. Observations were also made of general environment related to falls prevention, staff and resident interactions and actual area where incident occurred.

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

A resident fell in their bedroom and sustained an injury. The resident was assessed and subsequently transferred to hospital. The home submitted a Critical Incident Systems (CIS) report after the incident. Review of the CIS report stated that the resident was found by a PSW on the floor.

Interview was conducted with a Personal Support Worker (PSW) who said that she would refer to the Kardex in Point Click Care if she required information on resident's mobility or fall interventions. The PSW said that they were assigned to the identified resident on the morning of the incident. The PSW said that she was assisting the resident with their morning activities of daily living. The PSW said that they assisted resident in dressing. The PSW said that the resident then proceeded to ambulate towards the washroom. The PSW then said they heard a resident screaming across the hall. The PSW said she left resident alone while she attended to the other resident. She said she then heard a loud noise and turned and saw the resident lying on the floor.

Interview was conducted with another PSW who was working down the hall on the morning of the incident. The PSW said that they were assisting another resident down the hall from where the resident who fell resided. The PSW heard a loud noise and went out into the hallway which is where she saw the PSW assigned to the resident who had fallen. The PSW said that the other PSW working with the resident who had fallen had been in another resident room at the time she heard the loud noise.

Record review was completed of the resident's care plan in Point Click Care at the time of the incident. The care plan stated a focus of "limited physical mobility related to balance" with a goal of "will maintain current level of mobility". The intervention related to the focus stated "requires one staff assistance for mobility".

Interview was completed with the Director of Care who confirmed that the care plan stated that the identified resident required one person assist for mobility. She said that the PSW should not have left the resident unattended while ambulating as the care plan stated the resident required one person assist for mobility.

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 the resident as specified in the plan, to be implemented voluntarily.

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.