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

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
Feb 10, 2014	2014_211106_0003	001-14, 002-14, 004-14	Critical Incident System

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT
PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

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

MARGOT BURNS-PROUTY (106)

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): January 15, 16, 17, 2014

The following logs were reviewed as part of this inspection: Log# S-000001-14, S-000002-14, S-000004-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Food Services Manager, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Two critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care, indicated that resident #011 fell forward out of their wheelchair onto the floor, sustained injury and was transferred to hospital for assessment.

The electronic and most current version of resident #011's care plan document, dated December 31, 2013, was reviewed and in the section titled "Risk of Injury from Falls" the following intervention was found: When transferring resident in wheelchair from point A to point B always ensure that a table top restraint is applied to prevent them from falling forward out of their wheelchair.

On January 16, 2014, the inspector reviewed the care plan document for resident #011 found in the PSW binder, this binder is where the PSWs access care plan documents, as they do not have access to the electronic care plans. The care plan document found in the binder did not contain the most current version (dated December 31, 2013) of the section titled, "Risk of Injury from Falls". It contained a November 21, 2013, version of the section titled, "Risk of Injury from Falls" and this version did not identify interventions contained in the most current version of the care plan document (December 31, 2013) to prevent the resident from falling forward out of their wheelchair.

The inspector asked staff member #S-100, if the newer version should have been placed in the PSW binder when the plan was updated and they stated "Yes". The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate access to it. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it, specifically in regards to resident #011, to be implemented voluntarily.

Issued on this 10th day of February, 2014

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