Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of Inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
August 30, 2010	2010_121_9570_30Aug113757	Follow-up to a Critical Incident L-000564 M570-000009-10

Licensee/Titulaire
Corporation of the County of Grey
595 9th Ave. E., Owen Sound ON N4K 3E3

Long-Term Care Home/Foyer de soins de longue durée
Rockwood Terrace
575 Saddler St. E., Durham, ON N0G 1R0

Name of Inspector(s)/Nom de l'inspecteur(s)
Elizabeth Elvidge (121)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow-up to a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Director of Care and an RPN.

During the course of the inspection, the inspector: visited the resident, reviewed the care plan, reviewed the Dr's orders, reviewed the Progress Notes and the assessments.

The following Inspection Protocols were used in part or in whole during this inspection:
Falls Prevention and Management Program
Pain Management

☐ There are no findings of Non-Compliance as a result of this inspection.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, c. 8, s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

The plan of care available to the non-registered staff does not address the fracture including nursing interventions.
The plan of care available to the non-registered staff does not address pain related to the fracture.
The plan of care available to the non-registered staff does not indicate modifications to the physio therapy program as a result of the fracture.

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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 with a plan of care that provides clear instructions to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, c. 8, 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.

Findings:
The staff did not follow the transfer instructions as specified in the plan of care.

Inspector ID #:	121

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 with ensuring the staff follow the instructions on the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Regs. 79/10,s36
Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:
According to the Director of Care, this resident would have been a two person transfer if the mechanical lift not available. The resident was transferred from chair to bed by one PSW.

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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 staff use safe transferring devices and techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Regs. 79/10,s48(2)(b)
Each program must, in addition to meeting the requirements set out in section 30, provide for assessment and reassessment instruments.

Findings:
No evidence of assessment or re-assessment instruments in the Home's Falls Prevention and Management program relating to post falls.

Inspector ID #:	121

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Elizabeth Elvidge
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). August 31/10