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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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
Oct 10, 2013	2013_226192_0014	L-000720-13	Critical Incident System

Licensee/Titulaire de permis

SAINT LUKE'S PLACE
1624 Franklin Blvd., CAMBRIDGE, ON, N3C-3P4

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

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD, CAMBRIDGE, ON, N3C-3P4

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 26, 2013

Long Term Care Homes Inspectors Ali Nasser and Rae Nylander-Martin participated in the completion of this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Falls Coordinator, and registered staff.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, and incident reports.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary.

In 2013 a Care Conference was held that included registered staff and Personal Support Workers responsible for the care of resident #001.

Interview with the Falls Coordinator indicated that during resident #001's care conference the resident's ability to lean forward in the wheelchair and risk of falling from the wheelchair was discussed and a plan of action, including tilting of the wheelchair to prevent the resident from falling forward out of the chair, was discussed.

The plan of care dated in 2013 was reviewed and not revised to include interventions discussed at the Care Conference, including the need to tilt resident #001's wheelchair to prevent the resident from falling from the chair.

In 2013 resident #001 sustained a fall from the wheelchair resulting in a head injury. The homes investigation, done at the time of the fall, identified that resident #001's wheelchair had not been tilted when the resident was returned to the bedroom after supper.

The licensee failed to ensure that the plan of care was reviewed and revised when resident #001's care needs changed. [s. 6. (10) (b)]

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 ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Interview identified that Resident #001 was known to be at risk of falling from the wheelchair and that during the Care Conference held in 2013 the risk of falling from the chair, due to leaning forward while in the chair and interventions to minimize this risk were discussed in the presence of staff and family.

A review of the progress notes related to the 2013 Care Conference for resident #001 does not include the identified risk of falling from the wheelchair.

A review of the progress notes from May 2013 to September 2013 does not identify resident #001's risk of leaning forward in the wheelchair, or the risk of falling from the wheelchair, although interview identified that the resident was known by staff to be at risk.

The plan of care for resident #001 does not include the identified risk of leaning forward in the wheelchair or the risk of falling from the wheelchair although interview identified that the resident was known by staff to be at risk and that the risk had been discussed at the Care Conference occurring in 2013 prior to the plan of care being reviewed.

Resident #001 fell from their wheelchair and sustained a head injury in 2013. [s. 30. (2)]

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 ensuring that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 10th day of October, 2013

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

Debora Saville (192)