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
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, 4lém étage
London ON N6B 1R8

Téléphone: 519-675-7680
Télécopieur: 519-675-7685

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 28, 2011	2001-155-1002-28Feb115116	L-00229 Critical Incident

Licensee/Titulaire
Saugeen Valley Nursing Center Ltd., 465 Dublin Street, Mount Forest, ON N0G 2L3

Long-Term Care Home/Foyer de soins de longue durée
Saugeen Valley Nursing Center, 465 Dublin Street, Mount Forest, ON N0G 2L3

Name of Inspector(s)/Nom de l'inspecteur(s)
Sharon Perry # 155

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection regarding a fall.

During the course of the inspection, the inspector spoke with: Administrator, Director of Resident Care and Nurse Clerk.

During the course of the inspection, the inspector: reviewed identified resident's health records, observed the "**RN plus**" bed alarm system, and reviewed registered staff schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Sufficient Staffing

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

3 WN
1 CO: CO # 001

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, S.O. 2007, c.8, s.8(3)**
Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings:

1. Registered Staff schedule indicated that when the identified resident was found on the floor the Registered Practical Nurse (RPN) was working nights (11pm to 7am) with no Registered Nurse (RN) in the home.
2. Registered Staff schedule for the period of January 17, 2011 to February 28, 2011 indicates that there was no Registered Nurse coverage on the following shifts:
    - Jan 17-30, 2011--nights
    - Jan 31, 2011--nights
    - Feb 1, 2011--days and nights
    - Feb 2, 2011--nights
    - Feb 5, 2011--7pm-7am
    - Feb 6, 2011--7pm-7am
    - Feb 7, 2011--7pm-11pm
    - Feb 8, 2011--6pm-11pm
    - Feb 11, 2011--evenings and nights
    - Feb12-14, 2011--nights
    - Feb 15, 2011--days and nights
    - Feb 16-17, 2011--nights
    - Feb 18, 2011--days and nights
    - Feb 19-20, 2011--nights
    - Feb 22-24, 2011--evenings
    - Feb 25-27, 2011--nights

Day shift is 7am to 3pm; evening shift is 3pm to 11pm; and night shift is 11pm to 7am.

Additional Required Actions:

CO # - 001 will be served on the licensee.

WN #2: The Licensee has failed to comply with **O.Reg. 79/10, s.49(2)**
Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

1. The identified resident was found lying on the floor. Assessment did not include any vital signs at the time of the fall.
2. The identified resident was complaining of pain. The RN documented that a chest assessment was done. Assessment at this time did not include any vital signs.
3. The identified resident was having pain and difficulty breathing. Vital signs were done at this time and the resident was transferred to hospital as the identified resident required further medical interventions.

WN #3: The Licensee has failed to comply with **O.Reg. 79/10, s.90(2)(b)**
The licensee shall ensure that procedures are developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

Findings:

1. It is documented in the progress notes of the identified resident that the chair alarm was not working properly. The Maintenance Communication Forms were reviewed for the period of January 13-31, 2011 and there were no notations made regarding the chair alarm.
2. It is documented in the progress notes of the identified resident that the bed alarm did not work. The Maintenance Communication Forms for the period of February 2-27, 2011 were reviewed and there were no notations made regarding the bed alarm.

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. Sharon Perry
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). April 11, 2011

Ontario

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Sharon Perry	**Inspector ID #**	155
Log #:	L-00229		
Inspection Report #:	2011-155-1002-28Feb115116		
Type of Inspection:	Critical Incident		
Date of Inspection:	February 28, 2011		
Licensee:	Saugeen Valley Nursing Center Ltd., 465 Dublin Street, Mount Forest, ON N0G 2L3		
LTC Home:	Saugeen Valley Nursing Center, 465 Dublin Street, Mount Forest, ON N0G 2L3		
Name of Administrator:	Lisa Soehner		

To Saugeen Valley Nursing Center Ltd., you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: LTCHA, 2007, S.O. 2007, c.8(3)
Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Order: The licensee is required to prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s.8(3). Please submit plan to Duty Inspector at LondonSAO.moh@ontario.ca quoting Log # L-00229.

Grounds:

1. Registered Staff schedule indicated that when the identified resident was found on the floor the Registered Practical Nurse (RPN) was working nights (11pm to 7am) with no Registered Nurse (RN) in the home.
2. Registered Staff schedule for the period of January 17, 2011 to February 28, 2011 indicates that

there was no Registered Nurse coverage on the following shifts:

- Jan 17-30, 2011--nights
- Jan 31, 2011--nights
- Feb 1, 2011--days and nights
- Feb 2, 2011--nights
- Feb 5, 2011--7pm-7am
- Feb 6, 2011--7pm-7am
- Feb 7, 2011--7pm-11pm
- Feb 8, 2011--6pm-11pm
- Feb 11, 2011--evenings and nights
- Feb12-14, 2011--nights
- Feb 15, 2011--days and nights
- Feb 16-17, 2011--nights
- Feb 18, 2011--days and nights
- Feb 19-20, 2011--nights
- Feb 22-24, 2011--evenings
- Feb 25-27, 2011--nights

Day shift is 7am to 3pm; evening shift is 3pm to 11pm; and night shift is 11pm to 7am.

This order must be complied with by:	April 26, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 11 day of April 2011.	
Signature of Inspector:	Sharon Perry
Name of Inspector:	Sharon Perry
Service Area Office:	London Service Area Office