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
Apr 22, 2013	2013_171155_0013	L-001822-12 & L-000126-13	Critical Incident System

Licensee/Titulaire de permis

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 ou des inspecteurs

SHARON PERRY (155)

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): March 28, April 3, and April 9, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, RAI/Restorative Coordinator, Director of Therapeutic Programs, Nurse Clerk, Registered Nurse, Physiotherapy Aide, 2 Personal Support Workers and 2 Residents.

During the course of the inspection, the inspector(s) toured resident living areas; observed resident and staff interactions; observed staff assisting residents with care; reviewed resident clinical records; reviewed home's risk management incident reports pertaining to this inspection; and reviewed the home's policies relevant to this inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Responsive Behaviours

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The home's policy on Responsive Behaviour Management (NUM-B-180) was reviewed.

The licensee failed to comply with the above policy as evidenced by:
-Resident #1 and Resident #3 were involved in an incident. Staff had to assess and treat the injuries. The physician was not notified of this incident until 3 days after incident occurred.
-Resident #1 and Resident #2 were involved in an incident resulting in injury. The physician was not notified until the day after the incident.
-Resident #1 and Resident #6 were involved in an incident resulting in injury. The physician was not notified of this incident until the day after the incident.
This was confirmed by the Director of Care. [s. 8. (1)]

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 plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. During this inspection a review of resident clinical records revealed three incidents of resident to resident abuse resulting in injury that were not immediately reported to the Director. This was confirmed by the Director of Care. [s. 24. (1) 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 to ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. An identified resident was admitted to the home during the second quarter of 2012. The resident was on some medication to help with managing behaviours.
During the six month period following admission the resident was involved in seven incidents. Four of these resulting in physical injuries and 3 causing no physical injuries.

During interview with the Director of Care she confirmed that the physician was aware of all the above incidents as they had reviewed the internal risk management incident reports. Despite the above incidents, there was no change to the resident's medication for managing behaviours until after the seventh incident. [s. 26. (3) 17.]

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 the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes drugs and treatments, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director no later than one business day after the occurrence of the incident of:
-A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

An identified resident eloped from the home. This incident was not reported to the Director until after the Inspector advised the home on April 3, 2013 that this had not been reported. The home did submit the critical incident on April 5, 2013. [s. 107. (3)]

Issued on this 22nd day of April, 2013

[redacted]

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