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 26, 2014	2013_215123_0022	H-000488-13,H-000543-13	Complaint

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET, WINDSOR, ON, N9G-1J6

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

SHELBURNE NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
200 ROBERT STREET, SHELBURNE, ON, L0N-1S1

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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 5, 6, 9, 10 and 11, 2013

During the course of the inspection, the inspector(s) spoke with the resident, the General Manager, the physician, the physiotherapist, the physiotherapist assistant, the restorative care coordinator, registered staff, and personal support workers.

During the course of the inspection, the inspector(s) reviewed the home's records including policies and procedures, reviewed residents' records including care plans, observed equipment and observed resident care.

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

Personal Support Services

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.) 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. s. 6. (1) The licensee of a long-term care home failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).
The plan of care of an identified resident #002 was reviewed and it did not contain information related to the planned physiotherapy care for the resident; the goals that the physiotherapy care is intended to achieve and it did not provide clear directions to staff and others who provide direct care to the identified resident. The physiotherapist assistant was interviewed and provided specific details, related to the physiotherapy plan of care for the identified resident. The physiotherapist assistant was unable to locate the interventions that are in place for the identified resident #002 on the resident's plan of care. Also, the physiotherapist assistant identified an additional change to the identified resident's #002 physiotherapy plan of care related to the change in the weight being used and this information was also not included in the identified resident's plan of care. The physiotherapist was interviewed and provided detailed information related to the physiotherapy care being provided to the identified resident #002. However, specific information related to the physiotherapy assessment, interventions and goals in place for the identified resident #002 as stated by the physiotherapist was not included in the resident's plan of care provided to the inspector. This information was documented in the resident's #002 Quarterly Assessments and Interdisciplinary Care Conference notes. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
The Physician's Order record for identified resident #001 was reviewed and the physician ordered that the resident #001 was to receive two pre-operative medications. The resident's #001 Medication Administration record was reviewed and only one of the pre-operative medications were documented as being administered as ordered. Progress Notes were reviewed and it is noted that the resident #001 did not receive the pre-operative medications as ordered. Registered staff was interviewed and confirmed that the resident #001 only received one of the pre-operative medications that were ordered because it remained on hold. [s. 131. (2)]

Issued on this 26th day of February, 2014

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

M. GRAY