

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

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 19, 2021	2021_805638_0019	013917-21	Other

Licensee/Titulaire de permis

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 Smooth Rock Falls ON P0L 2B0

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

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 Smooth Rock Falls ON P0L 2B0

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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): September 13 - 16, 2021.

This inspection is a Sudbury Service Area Office initiated inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Housekeeping/Dietary Manager, Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance staff, Housekeeping staff, Cooks, residents and their families.

The Inspector also conducted daily walk through of resident care areas, observed the provision of care and services to residents, staff to resident interactions, meal services, medication pass and reviewed relevant resident care records as well as policies and procedures.

The following Inspection Protocols were used during this inspection:

Dining Observation

Falls Prevention

Infection Prevention and Control

Medication

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written heat related illness prevention and management plan for the home.

Amendments to the Ontario Regulation 79/10 effective May 15, 2021, outlined the requirement for a written heat related illness prevention and management plan that must be developed in accordance with evidence-based practices.

The DOC identified that the home did not currently have a written heat related illness prevention and management plan at the home because the home was controlled with central air conditioning.

Sources: April 1, 2021, memo titled Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements; and interviews with the DOC. [s. 20. (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 there is a written heat related illness prevention and management plan developed and implemented for the home, which is in effect between May 15 and September 15 of every year and any day in which the outside or inside temperature reaches 26 degrees Celsius at any point in the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

- 1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).**
- 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).**
- 3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that temperature was measured and documented in writing at minimum in two resident bedrooms in different parts of the home and one resident common area.

Amendments to the Ontario Regulation 79/10 effective May 15, 2021, outlined the requirement for licensees to measure and document the air temperature, at a minimum, in certain specified areas in the LTC home at specified intervals.

Maintenance staff #104 identified that they conducted a temperature check at the nurses' station and conducted a walkthrough of the home to ensure air temperature was comfortable each morning, however, the temperature check was not documented. The DOC identified that they did not check the temperature in two resident bedrooms and did not document the temperatures at the nurses' station.

Sources: April 1, 2021, memo titled Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007, related to enhanced cooling requirements; and interviews with the DOC. [s. 21. (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 that temperature is measured and documented in writing in at minimum two resident bedrooms in different parts of the home and one resident common area at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary, related to their fall interventions.

A resident's care plan outlined that they required certain interventions to manage their risk of falls. Observations identified that these intervention were not put in place for the resident. PSW #105 indicated that the resident required other interventions. RPN #102 identified that the interventions were discontinued.

The DOC identified that the resident used the interventions at one time but due to their independence they had been discontinued. They identified that the interventions were just not removed from the resident's care plan.

Sources: Resident's plan of care; observations; and interviews with the DOC and other staff. [s. 6. (10) (b)]

Issued on this 19th day of October, 2021

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

Original report signed by the inspector.