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
Mar 18, 2014	2014_261522_0005	L-000132-14 & L-000155-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ESSEX
360 Fairview Ave West, ESSEX, ON, N8M-1Y6

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

SUN PARLOR HOME FOR SENIOR CITIZENS
175 TALBOT STREET EAST, LEAMINGTON, ON, N8H-1L9

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

JULIE LAMPMAN (522)

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): February 25, 2014

During this inspection critical incidents M579-000005-15 and M579-000009-14 were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Nursing, a Registered Nurse and 2 Health Care Aides.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, policy and procedures related to falls prevention, staff training records, observed provision of resident care and staff resident interactions on the home's secured unit.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 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 licensee failed to ensure that the Fall Prevention and Management Program was complied with in respect to Registered Nursing staff initiating a post fall Head Injury Routine for all unwitnessed resident falls.

The home's Fall Prevention and Management Program states Registered Nursing Staff are to initiate a Head Injury Routine (HIR) for unwitnessed falls and witnessed falls that have resulted in a possible head injury.

Review of five post falls assessments for two residents revealed that Registered Nursing staff did not initiate a Head Injury Routine after each unwitnessed fall.

Interview with the Assistant Director of Nursing confirmed that the expectation is that Registered Nursing staff are to initiate a Head Injury Routine for residents after an unwitnessed fall.

The licensee failed to ensure that the Fall Prevention and Management Program was complied with in respect to fall and post fall assessment and management. [s. 8. (1) (a),s. 8. (1) (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 a Head Injury Routine is initiated for all unwitnessed falls as per the home's Fall Prevention and Management Program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff receive annual falls prevention and management training.

O. Reg. 79/10, s. 221(1)states for the purposes of paragraph 6 of subsection 76 (7) of the Act, that falls prevention and management training shall be provided to all staff who provide direct care to residents.

Review of the home's Fall Prevention and Management Program revealed that all direct care staff shall have falls prevention and management training annually.

Interview with Registered Nursing staff revealed the staff member had not received any falls prevention training.

Review of staff training records revealed that falls prevention and management training took place on December 2013. Of the direct care staff trained 77% of Health Care Aides, 83% of Registered Practical Nurses and 83% of Registered Nurses received falls prevention and management training.

Interview with the Administrator and Assistant Director of Nursing confirmed the expectation that all direct care staff receive annual falls prevention and management training.

The licensee failed to ensure that all direct care staff receive annual falls prevention and management training. [s. 221. (2) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's written record was kept up to date when the resident passed away in hospital.

Review of the resident's Discharge MDS Assessment indicated that the resident was discharged to hospital with an anticipated return. Resident's progress note indicated that the resident was in hospital with a fractured hip and an update was pending.

The resident passed away while in hospital. Review of the resident's chart did not reveal any documentation pertaining to the death of the resident.

Interview with the Administrator and Assistant Director of Nursing confirmed the expectation that the resident's chart contain documentation regarding the resident's death.

The licensee failed to ensure that the resident's written record was kept up to date at all times. [s. 231. (b)]

Issued on this 19th day of March, 2014

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