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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_276537_0033	027415-16	Resident Quality Inspection

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD SUITE 301 MISSISSAUGA ON L5N 2X4

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

TILBURY MANOR NURSING HOME
16 FORT STREET P.O. BOX 160 TILBURY ON N0P 2L0

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

NANCY SINCLAIR (537), NANCY JOHNSON (538), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 12, 13, 14, 15 and 16, 2016

The following intakes were completed within the RQI:
Log #000527-16/CI 1064-000009-15 related to a fall.
Log #028013-16/CI 1064-000004-16 related to allegations of abuse to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument(RAI)/Restorative Registered Nurse, Recreation Manager, Maintenance Manager, three Registered Nurses(RN), five Registered Practical Nurses(RPN), nine Personal Support Workers(PSW), Residents' Council Representative, Family Council Representative, residents and families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed assessments, policies, procedures and training records of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

An assessment was completed for an identified resident. Review of the care plan and the home's symbols for identification of care needs to staff was non consistent with the assessment.

Observation of the identified resident revealed care being provided that was not consistent with the assessed needs of the resident.

Personal Support Worker (PSW) #106 and #108 stated that care for the resident was provided by the staff in a way that was also not consistent with the assessment. Registered Nurse (RN) #105 explained a different care need for the resident.

The Director of Care (DOC) #101 stated that following the completed assessment, the care provided to the resident should have been per the assessed needs. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The current plan of care for an identified resident indicated specific interventions for safety.

Personal Support Worker (PSW) #122, Registered Practical Nurse (RPN) #111, and Registered Nurse (RN) #102 identified the specific interventions required for safety for the resident as per the plan of care.

An assessment was completed for the resident indicating that the interventions as per the plan of care had not been implemented resulting in an incident occurring that resulted in injury to the resident.

The Director of Care (DOC) #101 stated that the plan of care was to be followed, and the identified interventions had not been implemented. [s. 6. (7)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Clinical record review for an identified resident revealed the resident had experienced a fall.
The home's policy titled "Falls Prevention – LTCM-G-30.00", effective date January 2015, stated that an electronic post fall assessment would be completed following a fall.

RAI/Restorative Registered Nurse #102 stated during Stage 1 staff interview that the clinical record for the resident did not include an electronic post fall assessment. The Director of Care #101 stated that a post fall assessment should have been completed using the home's assessment tool following the fall. [s. 49. (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, when a resident has fallen, the resident is assessed and that where the circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 23rd day of September, 2016

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

Original report signed by the inspector.