Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 25, 26, 30, 31, Nov 1, 2, 5, 6, 7, 2012	2012_159178_0007	Complaint

Licensee/Titulaire de permis

ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION
60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4

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

UKRAINIAN CANADIAN CARE CENTRE
60 RICHVIEW ROAD, ETOBICOKE, ON, M9A-5E4

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Nursing, Manager of Programs, Attending Physician, Registered Dietitian, Minimum Data Set (MDS) Coordinator, Documentation Nurse, Registered Staff, Personal Support Workers (PSWs), family member of a resident.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home policies and procedures, reviewed home training records.

The following LOG # was inspected during this inspection:
T-925-12.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Nutrition and Hydration

Pain

Responsive Behaviours

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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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 1 received end-of-life care when required in a manner that met the resident's needs.
Record review and staff and family interviews confirm the following:
Resident # 1 was diagnosed with several medical conditions, one of which was possibly caused by a terminal illness.
The resident's family was made aware of the diagnoses and chose not to pursue further investigations.
Over a period of approximately two months, the resident's family repeatedly expressed concerns to the home staff and management that the resident's pain was not controlled, and that the resident was not being kept comfortable. The resident also suffered from agitation, which according to staff, made the resident's pain management more challenging.
Approximately one week before the resident's death, the resident was assessed by a Palliative Pain and Symptom Management Consultant who informed the resident's daughter that the resident was displaying signs of deterioration and discussed end of life preparation approaches with her.
Palliative Care was not arranged or initiated for this resident until one week later, when the attending physician changed the resident's care level from 3 to 1 and ordered Palliative Care.
The resident died the following morning, before an initial Palliative Care Conference could be held.
[O.Reg.42]

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 every resident receives end-of-life care when required in a manner that meets their needs, 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 subsections:

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 using a clinically appropriate assessment instrument that is specifically designed for falls was conducted for an identified resident after the resident sustained two falls in within one month.
Resident # 1 sustained two falls from bed in one month, eleven days apart. Record review and staff interviews confirm that no post falls assessment was conducted after either fall, using a clinically appropriate assessment instrument that is specifically designed for falls, as per the home's usual process when a resident falls.
[r. 49]

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 where required, a post falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 8th day of November, 2012

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

Susan Sui (178)