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 Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Nov 28, 2019	2019_781729_0024	012710-19, 020574-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Summit Place
850 - 4th Street East OWEN SOUND ON N4K 6A3

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

KIM BYBERG (729)

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): March 25, 26 and 27, 2019.

The following intakes were completed in this critical incident inspection;
-Log #012710-19;
-Log #020574-19, both related to an injury that resulted in the transfer to hospital with significant change in status.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Office Manager, Registered Nurse, Registered Practical Nurse, Fall Prevention Lead RN, Personal Support Worker (PSW), and residents.

The inspector also observed resident rooms, common areas, observed residents and the care provided to them, reviewed relevant resident health care records, plans of care and policy and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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	Légende 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. (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 plan of care for resident #001 was provided as specified in the plan.

A Critical Incident Summary (CIS) report was submitted to the Ministry of Long Term Care (MLTC) on a specified date, that reported resident #001 had an unwitnessed fall with significant injuries.

The plan of care for resident #001 identified that multiple fall prevention interventions were in place including the use of a chair and bed alarm.

RN #103, PSW's #104, #106 and #107 stated that they were not aware that resident #001 was required to have a bed or chair alarm in place. PSW's #106 and #107 stated that when resident #001 fell, there was no bed or chair alarm in place to alert staff that the resident tried to get up, and may have fallen.

RN #105, the fall prevention lead for the home, shared that they initiated the bed and chair alarm intervention two months prior to the fall, and staff were not to remove the alarms without an assessment by an RN. They were unable to locate documentation that the bed or chair alarm was removed and confirmed that resident #001 should have had the bed and chair alarms in place at the time of their unwitnessed fall.

The licensee failed to ensure that the plan of care for resident #001, related to the bed and chair alarm was provided to the resident as specified in the plan. [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 provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.