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
Sep 22, 23, Nov 28, Dec 5, 12, 2011	2011_056158_0012	Critical Incident

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol, STURGEON FALLS, ON, P2B-2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL, STURGEON FALLS, ON, P2B-2Y6

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC), the Long-Term Care Unit Manager, the RAI Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN) and the Restorative Care Worker

During the course of the inspection, the inspector(s) reviewed the home's policy on Falls Prevention and Management (policy # 605-96), reviewed a resident's health care record, reviewed the home's education plan related to Falls Prevention and Management, and observed resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. A resident's plan of care does not set out clear direction related to the resident's anxiety. The doctor documented in the resident's progress notes that the resident expressed anxiety to a specific situation. The anxiety and the strategies to manage the anxiety were identified in the resident's progress notes.
Two RPNs were interviewed by the inspector on September 22/11 and stated that the resident continues to have the same anxieties and outlined the interventions that are usually successful. These interventions, however, were not included in the resident's plan of care.
2.A resident's plan of care does not set out clear direction related to Falls Prevention and Management. A resident fell in the hallway outside the unit as the resident was ambulating. The resident's plan of care does identify that the resident is at high risk to fall, however, the long term actions identified in the Critical Incident sent to the Ministry of Health and Long Term Care (MOHLTC) were not included in the resident's plan of care.
[LTCHA 2007, S.O 2007, c.8, s, 6(1)(c)]

Issued on this 15th day of December, 2011

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