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

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
Jan 26, Feb 11, 2014	2013_250511_0008	H-000352-13, H-000611-13	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET, WELLAND, ON, L3C-1Y5

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

ROBIN MACKIE (511), LISA VINK (168)

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): December 17, 18 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, registered staff, personal support workers and identified residents and family members.

During the course of the inspection, the inspector(s) reviewed home's applicable policy and procedures, clinical records and observation of resident care services.

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	
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. (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 care set out in the plan of care, was not provided to the resident as specified in the plan.

A. The plan of care for resident #004 identified that staff were to ensure that the bed was in the lowest position due to fall risk. In December, 2013, on two separate occasions, the resident was observed in bed, with the bed in a raised position, not lowered to the floor. Care was not provided to the resident as specified in the plan.
B. The plan of care for resident #001 identified the need to be supervised in all activity areas and the requirement for a secured unit for safety, due to wandering. In June 2013, the resident was taken, by a staff member, to an activity area, outside of the secured unit and was able to exit the home unaccompanied, without the knowledge of staff. The resident was not supervised as specified in the plan of care. [s. 6. (7)]

WN #2: 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 did not ensure where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

The home's Fall Prevention program (MP00-002) read residents who sustained falls within the home would have their falls assessed and analyzed using a collaborative professional team approach with a goal of reducing falls while minimizing injuries. Clinical records revealed resident #002 sustained multiple falls in August, 2013 and in September, 2013 sustained an injury from a fall that required hospitalization. On return from the hospital to the home in September, 2013 the resident continued to experience more falls. The Director of Care confirmed resident #002's falls were not assessed and analyzed by the home's collaborated professional team at the onset of the falls and was not placed on the "Falling leaf program" until November, 2013 after sustaining numerous falls in the home. The Director of Care confirmed resident #002 had sustained recurrent falls and these falls were not analyzed by the home's fall team with a goal of reducing falls while minimizing injuries as per their Falls Prevention program. [s. 8. (1) (b)]

Issued on this 12th day of February, 2014

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