Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 4, 2011	2011-165-2951-04Feb112620	Complaint H-00040

Licensee/Titulaire
United Mennonite Home for the Aged
4024 Twenty-Third Street
Vineland, ON
L0R 2C0

Long-Term Care Home/Foyer de soins de longue durée
United Mennonite Home
4024 Twenty-third Street
Vineland, ON
L0R 2C0

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

Tammy Szymanowski, Long Term Care Inspector

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the director of care, the RAI MDS coordinator, and registered nursing staff.

During the course of the inspection, the inspector: reviewed resident's health records and policies.

The following Inspection Protocols were used during this inspection: Critical incident response inspection protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s.6(10)(b)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

1. There is no evidence that an identified resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to an injury post fall. Members of the home's management staff confirmed that the resident's plan of care was not revised to reflect the resident's change in care needs.
2. There is no evidence that a pain assessment was completed when an identified resident sustained an injury after a fall. Progress notes in the resident's clinical health record indicate the resident experienced continued pain however; there was no clinical assessment to address the pain. Members of the homes management team confirmed that the last pain assessment completed for the resident was prior to the resident's injury despite the resident experiencing continued pain.

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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 ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg.79/10 s. 107(4)3.v
A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: (3)Actions taken in response to the incident, including, (v) the outcome or current status of the individual or individuals who were involved in the incident.

Findings:

1. The home did not provide updated information to the Director related to the outcome and current status after a resident sustained a fall and was sent to hospital related to a possible injury. The resident returned to the home however, the hospital records did not indicate the results of the x-ray taken and the home concluded on the critical incident report to the Director that an injury was not sustained. Once the home received a copy of the x-ray results, the Physician indicated that the resident had sustained an injury. The home then failed to update the critical incident report to the Director to reflect the injury and current status of the resident.

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WN #3: The Licensee has failed to comply with O.Reg.79/10 s.107(5)
The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Findings:

1. There is no evidence in an identified resident's clinical record that the home attempted to promptly contact the substitute decision maker (SDM) when the home learned of the resident's injury. The registered staff interviewed indicated they did not recall contacting family once learning of the injury and a message for the SDM was not left. The SDM was provided the information relating to the resident's change in condition when they made a routine evening phone call to the home.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Jyma June 30/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).