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
Nov 4, 2013	2013_214146_0056	H-000222-13,H-000381-13	Critical Incident System

Licensee/Titulaire de permis

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 ou des inspecteurs

BARBARA NAYKALYK-HUNT (146)

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): October 29, 30, 2013.

This inspection was conducted related to two critical incidents and concurrently with complaint inspection H-000353-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW's)and residents.

During the course of the inspection, the inspector(s) reviewed resident health records and policies and procedures related to falls management and observed resident care areas for falls prevention devices.

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

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. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan had not been effective. 2007, c. 8, s. 6 (10).
a) Resident #001's plan of care indicated that the resident was at risk for falls and had multiple falls in the past six months. Resident #001 had two falls with injury in April 2013 within three hours. The plan of care was not revised after the first fall even though care set out in the plan had not been effective.
b) Resident #002's admission plan of care indicated that the resident was at risk for falls and had a history of multiple falls. In June 2013, the resident had two falls within 24 hours. The plan of care was not revised after the first fall even though the care set out in the plan had not been effective.
This information was confirmed by the health record and the DOC. [s. 6. (10) (c)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

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 that the nursing policy and procedure manual related to falls prevention and management policy was complied with. O. Reg. 79/10, s. 8 (1).
a) The home's policy 03.10 related to falls management directed staff to do a falls assessment on residents every three months. Resident #001 had a falls assessment completed on admission in July 2012 and not again until the resident had a fall with injury in April 2013.
b) The policy directed staff to complete head injury routine if a confused resident or a resident with diagnosis of dementia had an unwitnessed fall. Resident #002 had 2 falls within 24 hours in June 2013. The resident demonstrated confusion several hours after the first fall according to the health record. Resident #001, confused and diagnosed with dementia, had an unwitnessed fall in April 14, 2013. Head injury routine was not implemented as per policy post fall for either resident.
This information was confirmed by the health records and by the DOC.

The above information was confirmed by the health record and the DOC [s. 8. (1)]

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 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, (b) is complied with, to be implemented voluntarily.

Issued on this 4th day of November, 2013

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

B NAYKALYK-HUNT