Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 01, 2021	2021_864627_0022 (A1)	011273-21	Critical Incident System

Licensee/Titulaire de permis

Foyer Hearst - Mattice - Soins De Sante
67-15th Street P.O. Box 1538 Hearst ON P0L 1N0

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

Foyer Des Pionniers
67 15th Street P.O. Box 1538 Hearst ON P0L 1N0

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This licensee inspection report has been revised to reflect changes to the grounds of the finding of non-compliance for s 6 (7) of the Long-Term Care Home's act. The Critical Inspection System inspection, #2021_864627_0022 was completed on September 21-23, 2021. A copy of the revised report is attached.

Issued on this 1 st day of October, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended 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): September 21-23, 2021.

The following intake was inspected during this Critical Incident System (CIS) inspection:

- One log related to a fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers and residents.

The Inspector conducted daily observations of the provision of care to the residents, staff to resident interactions, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control

During the course of the original inspection, Non-Compliances were issued.

2 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 care set out in the resident's plan of care, related to falls, was provided to the resident.

A resident had a fall which resulted in an injury that caused a significant change to their health status. The resident's care plan in effect at the time of the incident indicated a fall intervention that was not implemented, when the resident fell.

The Director of Care (DOC) acknowledged that the fall intervention for the resident was not implemented when the resident fell.

There was actual harm to the resident when the resident fell and the fall intervention was not implemented.

Sources: Critical incident report, resident's care plan, home's policy titled, "The Care Plan", interviews with a PSW, RN and DOC. [s. 6. (7)]

Additional Required Actions:

(A1)
The following Voluntary Plan of Correction has been amended.

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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the fall prevention and management program was evaluated and updated at least annually.

Ontario Regulation 79/10 specified that a fall prevention and management program was to be developed and implemented in the home. The program was to be evaluated and updated at least annually.

The DOC stated that a yearly evaluation and update had not been completed for the fall prevention and management program, for the year 2020.

There was no risk of harm to the resident from lack of completing the yearly evaluation of the fall prevention and management program for the year 2020.

Sources: interview with DOC [s. 30. (1) 3.]

Issued on this 1 st day of October, 2021 (A1)

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

Original report signed by the inspector.