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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 1, 13, 15, 2012	2012_140158_0009	Critical Incident

Licensee/Titulaire de permis

BLIND RIVER DISTRICT HEALTH CENTRE
525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0

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

BLIND RIVER DISTRICT HEALTH CENTRE - ELDCAP UNIT
525 CAUSLEY STREET, P.O. BOX 970, BLIND RIVER, ON, P0R-1B0

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 spoke with the Administrator, the Chief Nursing Officer, the Manager of the LTC unit, the RAI coordinator, Registered Nursing Staff, Personal Support Workers, Residents and Families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed resident care delivery, reviewed health care records and reviewed various
policies and procedures.
The following log and Critical Incident Report was reviewed as part of this Critical Incident Inspection: S-000886-12, 2795-000001-12.

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	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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.
The home's policy "Falls Prevention and Management Program Protocol" was reviewed by the Inspector on July 30/12. Although the policy identifies generic strategies to manage falls, it fails to include a review of the resident's drug regime or the implementation of restorative care approaches. [O.Reg 79/10, s. 49.(1)]
2. According to CI # 2795-000001-12, resident # 01 was found on the bathroom floor. The resident had stated that they were trying to get ready for breakfast and tripped over their feet. The resident was transferred to Sault Area Hospital (SAH) where they had surgery for a fracture.
A falls risk assessment was found in point click care however it was dated July 2011. A more current version of the fall risk assessment was not found. A quarterly assessment under a multi-disciplinary conference in point click care was found dated July 2012. There was no reference made to a fall risk or a fall assessment or any problems the resident had with falls.
The computerized progress notes were reviewed by the Inspector on July 31/12 and a notation by the physiotherapist regarding resident # 01 continued improvement, related to muscle strength and exercises was found. Notation of the fall was made by staff # 102 on two separate days, however no reference to a post fall assessment was made. The Inspector was unable to review Resident # 01 health care record as this was not in the home but on the Acute Care unit of the hospital. A post fall assessment using a clinically appropriate assessment instrument that is designed for falls was not found to be completed. [O.Reg 79/10, s. 49.(2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. Resident # 01 who resides in the Elcap unit had not returned to the home from hospital during the inspection. The resident's health care record (chart) was not found by the Inspector. The Inspector was informed by staff S-105 on July 31/12 that the resident's chart was in the Acute Care unit of the hospital as the resident was being transferred to Blind River Hospital from Sault Area Hospital (SAH).
Although the resident resides in the Elcap unit, the home is not exempt from O Reg 79/10, s. 232 which identifies that " Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home." [O.Reg 79/10, s. 232.]

Issued on this 15th day of August, 2012

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