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
Jun 20, 2014	2014_256517_0028	L-000524-14	Critical Incident System

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

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

HERON TERRACE LONG TERM CARE COMMUNITY
11550 McNorton Street, WINDSOR, ON, N8P-1T9

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

PATRICIA VENTURA (517)

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): June 2, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Registered Nurses, One Registered Practical Nurse and five Personal Support Worker Staff.

During the course of the inspection, the inspector(s) Reviewed one resident health record, reviewed the home's policies and procedures relating to fall prevention and observed resident-staff interaction.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure the plan of care set out clear directions to staff and others who provided direct care to residents as evidenced by:

Review of the resident's most recent written plan of care revealed there was inconsistent directions provided regarding the resident's mobility status and the level of assistance needed.

Staff reported the directions provided in the resident's plan of care were confusing and unclear.

The Director of Care verified the plan of care should provide clear directions to staff. [s. 6. (1) (c)]

2. The licensee did not ensure the care set out in the plan of care was provided to the resident as specified in the plan as evidenced by:

The resident's plan of care listed interventions to prevent falls and ensure safety. The interventions listed to prevent falls and ensure safety were observed by the inspector not to be in place.

Staff confirmed the interventions listed in the resident's written plan of care to prevent falls and ensure safety were not in place.

The Director of Care verified the care set out in the plan of care should be provided to the resident as specified in the plan. [s. 6. (7)]

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 resident's plans of care set out clear directions to staff and others who provide direct care to residents and ensure that the care set out in the plan of care is provided to the residents as specified in the plan., to be implemented voluntarily.

Issued on this 20th day of June, 2014

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