Ontario

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2013	2013_139163_0021	S-000173-13, 332-13	Critical Incident System

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road, Box 179, Wawa, ON, P0S-1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0

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

DIANA STENLUND (163)

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): Sept 4, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered nursing staff and residents.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed Critical Incident (CI) reports, observed staff to resident interactions, reviewed health care records and home policies.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Minimizing of Restraining

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

---

1. Inspector reviewed a Critical Incident (CI) involving resident #332 who was injured as a result of a fall and was transferred to hospital. The CI report identifies that a registered staff member had assisted the resident with toileting, then positioned the resident in the standing position holding onto grab bars for assistance. The staff member then went to the sink, turning away from the resident. During that moment, the resident attempted to ambulate independently without the aid of their walker, moving towards their bed. The resident subsequently lost balance and fell. The resident's plan of care identifies that resident #332 requires one person assist with toileting and ambulation, and they are required to use a walker. The licensee has not ensured that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting resident #332, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The inspector reviewed a Critical Incident (CI) report whereby resident #332 was injured as a result of a fall and taken to hospital. The date of the CI and the date that the Director was informed was noted to be approximately 7 days apart. The licensee has not ensured that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): An injury in respect of which a person is taken to hospital. [s. 107. (3)]

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 when a CI occurs in the home, specifically with regards to where a resident is injured and taken to hospital, the Director is informed of the incident no later than one business day, followed by the report required under subsection (4), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The inspector reviewed the health care record for resident #173 that identified the use of a restraint. It was noted by the inspector that documentation did not include the reassessment of the resident and their restraint. The inspector interviewed registered nursing staff who confirmed that documentation of resident #173 while in their restraint, did not include reassessment. The licensee has not ensured that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

2. The inspector reviewed the health care record for resident #173 noting that the resident required a restraint. The inspector identified that documentation did not include all repositioning while the resident was in their restraint. The inspector interviewed registered nursing staff who confirmed that documentation did not include all repositioning that the resident received while in the restraint. The licensee has not ensured that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee has not ensured that the following are documented: All repositioning to the resident. [s. 110. (7) 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 that for those residents requiring a restraint, specifically resident #173, documentation includes reassessment and all repositioning to the resident, to be implemented voluntarily.

WN #4: 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. Inspector reviewed a CI that identified resident #173 had fallen at approximately 1845hr one evening and sustained injury. Inspector noted from the CI documentation (confirmed by nursing staff) that upon assessment of the resident immediately after the fall, the resident's left leg was bent out to the left, and the resident complained of left knee pain. On the same day at 1930hr, nursing documentation indicated that the resident's knee was noted to be somewhat swollen, warm to touch and that the resident complained of pain when repositioned. At 0200hr and 0300hr the next morning, documentation by nursing staff identified that the resident was continuing to complain of left knee pain. At 1030hr, just prior to being sent for x-rays, it was documented by registered staff that the resident's knee was still somewhat swollen and the resident continued to complain of pain. Documentation in the resident's health care record identified that the resident suffered a left hip fracture that required surgical repair. The inspector interviewed registered nursing staff who reported that after the fall, the resident was experiencing ongoing signs and symptoms that warranted further reassessment and investigation, however staff did not adequately reassess the resident. The licensee has not ensured 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. [s. 6. (10) (b)]

Issued on this 9th day of September, 2013

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

Diana Stenlund, #163