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
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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
Oct 10, 2013	2013_211106_0024	S-000304-13	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive, KENORA, ON, P9N-2W7

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

PINECREST
1220 VALLEY DRIVE, KENORA, ON, P9N-2W7

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

MARGOT BURNS-PROUTY (106)

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): August 14, 2013

The following log was reviewed as part of this Critical Incident inspection: Log # S-000304-13
Concurrent inspection completed during this inspection: #2013_211106_0023

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

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	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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).

Findings/Faits saillants :

1. The plan of care document found in the plan of care binder for resident # 022 indicates that in regards to transferring the resident requires 2 staff extensive assistance until injuries heal and staff may use griffin/cocoon sling. The checked area of the most recent "Lifting and Transferring Assessment OHS 020", indicates the resident is to be transferred by a sling-type lift procedure (EG. Golvo Griffin), has a handwritten note "Do to injuries prn". Neither of these documents provide clear direction as to when staff are to use the sling lift to transfer the resident.

Two "Resident Care & Safety Routine" sheets for resident #022 were also found, one in the plan of care binder and one on the resident's closet door. Under the title "Transfer Type & Mobility", the sheet found in the binder indicated, "Independent with walker on & off unit" and the sheet found on the resident's closet door indicated "Griffin lift, cacoon sling". On August 14, 2013, a RN reported that they thought that a sit to stand lift was used to transfer the resident for toileting, the RN clarified this by asking a nearby PSW how resident #022 was transferred, the PSW reported that the resident is transferred with a sit to stand lift.

The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (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 written plan of care for resident #022 sets out clear direction to staff and others who provide care to the resident, specifically in regards to the resident's transferring needs, to be implemented voluntarily.

Issued on this 11th day of October, 2013

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