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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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
Aug 28, 2014	2014_226192_0029	000391-14; 001754-14	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

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 27, 2014

This Critical Incident Inspection related to Fall Prevention was conducted concurrently with Complaint Inspections 003999-14 and 004008-14 and Critical Incident Inspection L-000572-14.

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant General Manager, Director of Care, Assistant Director of Care, and Kinesiologist.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, and policy and procedure.

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. (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. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 had a plan of care related to falls that indicated staff are to provide frequent safety checks and that the resident is on the Falling Star program.

Interview with the Director of Care (DOC) confirmed that these statements do not provide clear direction to staff. The DOC indicted the intent of the statements are that the resident be routinely checked hourly and staff are to accompany the resident when they attempt to ambulate.

The plan of care for resident #001 does not provide clear direction to staff in relation to interventions for fall prevention and injury reduction. [s. 6. (1) (c)]

2. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

A) Resident #002 sustained two falls with injury in 2014 and a fall with injury on a specified date in 2014. The resident was reassessed by the Kinesiologist in 2014 and changes to the plan of care were proposed, including the need for close supervision,

staff to provide assistance whenever the resident was walking or transferring and that the resident should remain in common areas so staff can monitor and intervene as necessary.

Interview with the Kinesiologist confirmed that the plan of care for resident #002 did not include these identified interventions.

B) Resident #004 sustained a fall that resulted in injury in 2014. In 2014 the resident was sent to hospital for diagnostic testing and it was determined that the resident sustained injury. On a specified date in 2014, the resident returned to the home from hospital.

Assessments were conducted at the time of return to the home and it was determined that resident #004 required the use of the sit to stand lift for all transfers. Interview with the Director of Care confirmed that the plan of care was not updated to include this change for resident #004.

In 2014 resident #004 was assessed by the Kinesiologist who determined that a transfer tool would be appropriate for the resident. Interview with the Director of Care and Kinesiologist confirmed that the plan of care was not updated to include the use of the transfer tool.

The licensee failed to ensure that the plan of care for resident #004 was reviewed and revised following an assessed change in care need. [s. 6. (10) (b)]

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 ensuring 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 or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 28th day of August, 2014

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