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
Sep 12, 17, 18, 2012	2012_099188_0035	Critical Incident

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0

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

MELISSA CHISHOLM (188)

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 the Administrator, the Director of Care, the Assistant Director of Care, Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Responsive Behaviours

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

Specifically failed to comply with the following subsections:

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. Inspector reviewed the health care record for resident #009. Inspector noted the resident sustained a fall for which they were transferred to hospital. Inspector was unable to locate a completed post-fall assessment for this fall. It was reported to the inspector by the Director of Care that previously post-fall assessments were not being completed regularly and that the home continues to educate staff in this area. The licensee failed to ensure that when a resident has fallen, the resident is assessed and 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)]
2. Inspector reviewed the health care record for resident #008. Inspector noted the resident sustained a fall for which they were transferred to hospital. Inspector was unable to locate a completed post-fall assessment for this fall. Inspector spoke with the Assistant Director of Care who confirmed a post-fall assessment was not completed. The licensee failed to ensure that when a resident has fallen, the resident is assessed and 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)]

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 when a resident has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls., to be implemented voluntarily.

Issued on this 18th day of September, 2012

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