Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2019	2019_538144_0037	016278-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Sumac Lodge
1464 Blackwell Road SARNIA ON N7S 5M4

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

CAROLEE MILLINER (144)

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): September 10, 2019.

The following intake was inspected during this inspection:
Log 016278-19, CIS 2573-000018-19 related to plan of care and falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Activation Manager, Physiotherapist, one Registered Nurse, one Registered Practical Nurse, one Personal Support Worker and one Restorative Care Aide.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. (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 has failed to ensure that the care set out in the plan of care for one resident was provided to the resident as specified in the plan.

One Critical Incident (CI) report on review included that one resident had a witnessed fall on one identified date that resulted in an injury.

Review of the clinical record for the resident revealed that the resident experienced a previous fall on one identified date and was assessed by the Physiotherapist (PT) who documented a change in the residents' physical status.

The PT's documented assessment also included how the change in the residents' physical status had impacted their activities of daily living and that they (PT) had updated the residents' health information.

The written care plan for the resident at the time of the PT's assessment included that the resident needed assistance of one person for transfers and reminders to use their assistive devices.

The PT explained that the resident had lost physical strength over a defined period of time and that specific abilities had become harder for the resident to accomplish.

One Registered Practical Nurse (RPN) and one Restorative Care Aide (RCA) during separate interviews, shared what the residents' physical capabilities and limitations were related to their ambulatory skills.

The home's Visitor and Volunteer sign in record revealed the volunteers that attended the home on one specific date during a specified time period.

The Activation Manager (AM) said that part of the volunteer duties for one specific program is for the volunteers to accompany residents to the program located at the far end of the west corridor and that the accompaniment could be accomplished by pushing residents in their wheelchairs or walking along side ambulatory residents and those using walkers.

The AM said the home did not have a formal process in place requiring volunteers to report to the nurse's desk to inquire about a residents abilities.

The home's nurse's desk is located at the top end of the north, east and west corridors. The AM said the furthest end of each corridor is a distance of more than 32 metres from the nurse's desk.

The Director of Care (DOC), one Registered Practical Nurse (RPN) and one Registered Nurse (RN) shared that one of the volunteers, unknown to them, walked up the north corridor to the resident who was sitting in a chair at an activity table and walked alongside the resident to a scheduled program at the far end of the west corridor.

The DOC, RPN, and RN said when the program was finished, the volunteer walked with the resident to the same chair in the north corridor, that no one knew who assisted the resident from a sitting to standing position prior to the scheduled program and from a standing to sitting position when the program was finished.

The DOC, one RPN and one RN agreed that the resident and the volunteer would have walked past registered and non-registered staff when walking to and from the program and that none of the personnel working on the identified date interrupted them.

The DOC, one RPN and one RN agreed that they did not know if the volunteer or a PSW transferred the resident from the chair to a standing position or from a standing to a sitting position when the program was finished and if the resident rested during the walk to and from the program.

On the same date, after returning to the north corridor chair, the resident was observed by a PSW completing an independent action and falling to the floor.

Documented minutes to the Falls Debrief Meeting for this resident questioned how the resident was “handed off” from one shift to the other and how the volunteer walked the resident with their limitations from the north corridor to the west lounge and back again.

The debrief minutes further recommended increased communication between volunteers and staff related to mobility of residents.

The Administrator and DOC were not able to provide a formalized plan related to the identified Falls Debrief Meeting's recommendation for improved communication between volunteers and staff.

The home failed to ensure that one identified residents' needs were provided as specified in the plan of care. [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 that the care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

Issued on this 16th day of September, 2019

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

Original report signed by the inspector.