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 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
Apr 17, 2019	2019_626501_0009	017487-17	Complaint

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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 27, 28, 29, April 1, 2, 3, 4, 5, 9, 10, 11, 2019.

This inspection was inspected concurrently with inspection #2019_626501_0008.

The following complaint intake was inspected:
#017487-17 related to falls prevention and management and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), registered nurse (RN), registered practical nurses (RPN), personal support workers (PSW), and physiotherapist (PT).

During the course of the inspection, the inspector reviewed health care records and relevant policies and procedures.

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

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

An interview between inspector #607 and resident #030's substitute decision-maker (SDM) took place on an identified date related to complaint intake #017487-17. During this interview the SDM stated they were concerned because resident #030 had another fall on an identified date. According to the SDM, the resident was now using an identified assistive aid for mobility and had an identified type of alarm device.

Review of resident #030's plan of care indicated the resident had been assessed with significant risk for a fall related injury. An identified alarm was initiated in the plan of care as of an identified date. A progress note documented by physiotherapist (PT) #117 a few days later, stated that the resident's SDM continued to be concerned about the resident falling. The SDM was reassured that a different alarm device would be ordered pending approval by the Executive Director (ED). A review of all resolved and cancelled interventions in resident #003's written plan of care indicated that there was no documentation of this alternate alarm device.

A post fall assessment on an identified date indicated the resident was found on the floor in another resident's room by a visitor. There was no mention whether an alarm device had been sounded. An assessment the day later made by PT #117, indicated resident #030's alarm devices were in place.

An interview with Associate Director of Care (ADOC) #119 and PT #117 indicated they recalled resident #030 did have a different alarm device. An interview with ED #101 indicated they recalled being present when resident #030 was assessed for different types alarm devices.

An interview with ADOC #119 confirmed that an identified alarm device was not documented as having been assessed for resident #030 nor was it an intervention in their plan of care. The ADOC acknowledged the post fall assessment of the above mentioned fall failed to indicate whether any alarm device had been in use. ADOC #119 and ED #101 acknowledged that an identified type of alarm device to prevent falls for resident #030 should have been documented as having been assessed, as having been in place at the time of subsequent falls and as an intervention in the resident's plan of care.

The licensee has failed to ensure that any actions taken with respect to resident #030 under the falls prevention program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (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 to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 23rd day of April, 2019

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

Original report signed by the inspector.