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
Sep 10, 2014	2014_283544_0025	S-000376-14	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4

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

FRANCA MCMILLAN (544)

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): September 4, 5, 2014 related to:

Log # S-000376-14

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers, Residents and Families.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the Residents, staff to resident interactions, reviewed resident's health care records, care plans, kardexes, Falls Prevention and Management program and post-falls assessments.

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. (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. Resident # 001 was assisted to the bathroom with the assistance of Staff # 104.
Resident # 001's "knees buckled under them" and Resident # 001 fell to the floor.
There were no apparent injuries noted at the time of the fall.
Resident # 001 complained of increased pain and increased bruising. An X-ray was taken.
The X-ray identified that Resident # 001 sustained a fracture.

Resident # 001 sustained a fall with an injury.
Resident # 001's plan of care was reviewed by Inspector # 544 and identified that Resident # 001 was a 2 person transfer for toileting.
The home completed their investigation and as a result of this incident, Staff # 104 was terminated from employment at the home immediately.

The licensee has failed to ensure that, the care set out in the plan of care, was provided to the resident as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector # 544 reviewed the home's Fall Prevention and Management Program under Nursing- Risk management. This program was revised September 2013 and reviewed March 2014.
It is written as part of the program, that:
"1. Registered Staff are to complete a head to toe assessment after the fall.
2. Move the Resident, ensuring that proper lifting procedures are performed.
3. Observe for pain or difficulty weight bearing if no injury is evident
4. Document under the Risk Management tab in Point Click Care."

Inspector # 544 reviewed Resident # 001's health care record and could not find any documentation in relation to a head to toe assessment nor any documentation under the Risk Management tab in Point Click Care (PCC) in the health care record in relation to a head to toe assessment.
The only post falls assessment completed was a Post Fall Screen for Residents/Environmental Factors. A head to toe assessment was not completed for Resident # 001.
Staff # 100, 101 and Staff # 102 confirmed that a head to toe assessment was not completed.

The licensee failed to ensure that, where the Act or Regulation requires to put in place any plan, policy, protocol, procedure, strategy or system, that it is in compliance with and implemented with all applicable requirements under the Act; and is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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. Resident # 001 was assisted to the bathroom with the assistance of Staff # 104. Resident # 001's "knees buckled under them" and Resident # 001 fell to the floor. There were no apparent injuries noted at the time.
Inspector # 544 reviewed Resident # 001's health care record, progress notes, and other assessments and could not find a clinical post falls assessment completed for Resident # 001.

Staff # 100 # 101 and Staff # 102 confirmed that there was no post falls assessment completed for Resident # 001, using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that when Resident # 001 had fallen, the Resident did not have a post-fall assessment completed using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

Issued on this 10th day of September, 2014

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