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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2015	2015_270531_0008	/O-000685-14/O-000720-14/O-001316-14/O-001090-14/O-000587-14/O-000677-14/O-001239-14	Critical Incident System

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

SUSAN DONNAN (531)

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): March 23, 24, 25, 26 and 27, 2015.

The following inspection logs were included in this inspection:
Log #O-000685-14, Log #O-000677-14, Log #O-000720-14, Log #O-000587-14, Log #O-001239-14, Log #O-001316-14 and Log #O-001090-14

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Staff, Registered Practical Nurses, Registered Nurses, the Physiotherapist, a Physiotherapy assistant, the Director of Care, the RIA Coordinator and the Administrator.

During the course of the inspection the inspector reviewed resident health care records including physician orders and physiotherapy reports, the Falls Prevention Program and appropriate policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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. (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 resident plan of care was reviewed and revised when there was a change in the resident's care needs.

On a specified date a Critical incident report # 2977-000008-14 was submitted to the Ministry of Health and Long Term Care.
The Critical Incident report describes the incident as follows:
Resident fell and sustained an injury that significantly changed the resident's health status requiring transfer to hospital.

Resident #4's diagnoses include dementia and Arthritis.

On March 24, 2015 Resident #4's current plan of care was reviewed and identified the following:

Transferring: two staff to transfer with mechanical lift for all transfers. Resident is unable to participate and is totally dependent for the entire process.
Resident can weight bear for transfers PRN

Falls Risk: Encourage resident to use side rails or assistive devices properly
Reinforce need to call for assistance
Resident has a bed/chair alarm for use while in bed
Resident to wear proper and non slip footwear
Resident will wander off without walker. Monitor and encourage consistent use of walker

A March 25, 2015 interview with S108 and a review of the physiotherapy assessments confirm that Resident #4 no longer has the strength to stand for more than 10 seconds.

A March 24, 2015 interview with S104 (RPN) she confirmed that the current plan of care does not reflect Resident #4's change in status and health care needs.

The Director of Care was interviewed on March 25, 2015 and confirmed that the current plan of care does not reflect Resident #4's change in health status. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3.1) whereby the licensee did not ensure that an injury to a resident that resulted in a significant change in the resident's health condition was reported to the Director within three business days.

On a specified date a Critical Incident report # 2977-000008-14 was submitted to the Ministry of Health and Long Term Care.
The Critical Incident report states that on a particular date the resident fell and sustained an injury that significantly changed the resident's health status requiring transfer to hospital.

The resident diagnoses include Dementia and Arthritis.

In an interview on March 23, 2015 with Director of Care she confirmed the report was not submitted to the Director within three business days. [s. 107. (3.1)]

Issued on this 5th day of May, 2015

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

Original report signed by the inspector.