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
Aug 7, 2015	2015_395613_0012	017043-15, 019278-15	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LISA MOORE (613)

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): July 27, 28, 29, 30 & 31, 2015

Logs #017043-15 and #019278-15

During the course of the inspection, the inspector(s) spoke with Vice President Management, Administrator/Director of Care, Sienna Living Information Consultant, Registered Staff (RN/RPNs), Personal Support Workers and Residents.

Inspector conducted a walk through of resident home areas, observed the provision of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records, resident plans of care, various home policies and procedures and reviewed critical incident reports sent to the Ministry of Health and Long - Term Care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 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 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. The licensee failed to ensure that when resident #001 had fallen, the resident was assessed and that when the condition or circumstance of the resident required a post fall assessment, it was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On July 27, 2015, Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #001 had a fall. Resident #001 was found on the floor. The Critical Incident identified that resident #001 sustained some injuries. The resident was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that resident had sustained a fracture as a result of the fall. No further treatment was required. The resident later passed away.

On July 31, 2015, Inspector #613 reviewed #001's incident report regarding the fall, documentation in medecare and documentation in the resident's chart(paper forms). Inspector was unable to locate a Post Fall Assessment.

Inspector #613 reviewed the home's Falls Prevention Policy. The policy states that registered staff will complete an electronic post fall assessment by using the Post Fall Huddle or Fall Incident Report. Inspector could not locate a post fall assessment on the electronic medecare or paper form (Fall Incident Report). The policy also states that home will have a falls prevention and management program in place to reduce the incidence of falls and the risk of injury to residents.

Inspector #613 interviewed the DOC to inquire if the home used a post fall assessment. The DOC stated, "no we do not have one or not that I am aware of". The DOC confirmed the home does not have a post falls assessment form and that registered staff did not complete a post fall assessment following resident #001's fall on July 11, 2015. The DOC also stated that the home does not have a falls prevention and management program currently in place. [s. 49. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the report was written and submitted to the Director with in 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident by the licensee or staff that led to the report.

On July 27, 2015, Inspector #613 reviewed a Critical Incident that was reported to the director. The Critical Incident identified that resident #001 alleged S#101 neglected to meet their care needs on June 13, 2015. Resident stated that they had requested assistance with care and S#101 had spoken inappropriately to resident. Resident informed the DOC he did not want this staff member to provide their care or enter their room.

The alleged incident occurred on June 13, 2015. The Critical Incident was submitted by the home to the Director on July 2, 2015.

On July 30, 2015, Inspector #613 interviewed the DOC who admitted they were late in submitting the Critical Incident to the MOH-LTC. The DOC stated they had difficulty logging on to the Long Term Care Homes website and was unable to submit report. Initially, the DOC did contact the after hours telephone line on June 13, 2015 to report the incident; however, the report was submitted late to the Director and not until July 2, 2015. [s. 104. (2)]

WN #3: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to the hospital.

On July 27, 2015, Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #001 had a fall. Resident #001 was found on the floor. The Critical Incident identified that resident #001 had sustained some injuries. The resident was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that resident had a fracture as a result of the fall. No further treatment required. The resident later passed away.

The fall occurred on July 11, 2015. The Critical Incident was submitted to the Director on July 21, 2015.

On July 30, 2015, Inspector #613 interviewed the DOC who admitted they were late in submitting the Critical Incident to the MOH-LTC. The DOC confirmed that the critical incident was submitted late to the Director. [s. 107. (3) 4.]

Issued on this 7th day of August, 2015

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

Original report signed by the inspector.