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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 31, 2014	2014_266527_0005	H-000212-14	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

PEEL MANOR
525 MAIN STREET NORTH, BRAMPTON, ON, L6X-1N9

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

KATHLEEN MILLAR (527), DARIA TRZOS (561)

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): February 20 and 21, 2014.

The inspection conducted was related to one Critical Incident, Log #H000212-14.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Supervisor of Care (SOC), Personal Support Workers (PSWs), Registered Nursing staff and the Resident's family.

During the course of the inspection, the inspector(s) reviewed the residents health records, the home's policies and procedures, training records / educational materials, conducted observations throughout several units in common areas and resident rooms.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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. The Licensee did not ensure that care set out in the plan of care was provided to the Resident as specified in the plan.

(a) In December 2013 a re-assessment was completed for a Resident, and the re-assessment identified new interventions related to wandering. As a result the resident's written plan of care was updated.

(b) One of the new interventions for the Resident was hourly wandering and safety checks. The staff confirmed they are expected to document the whereabouts of the resident hourly. In review of the resident's health record, there was inconsistent documentation of the hourly safety checks.

(c) The staff also confirmed they did not know what the new interventions were on the resident's plan of care, and were not aware of the recent revisions. The staff stated they rely on the charge nurse to update them if there are any changes to the residents care and they were not informed.

The Resident was not checked hourly and direct care providers where not aware of the revised plan of care, subsequently the resident wondered into another resident's room where she had a fall with significant injury. [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 staff are providing care to residents as specified in the plan of care, to be implemented voluntarily.

Issued on this 31st day of March, 2014

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

Kathleen Millar