Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 24, 25, Apr 3, 4, 5, 17, 2012	2012_104196_0001	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court, 523 Algoma Street North, THUNDER BAY, ON, P7A-5C2

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

GRANDVIEW LODGE
200 LILLIE STREET, THUNDER BAY, ON, P7C-5Y2

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Life Enrichment/Activation Supervisor, Therapeutic Recreationist, Nursing Unit Support Workers (NUSW), Residents and Family members

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents of the home, reviewed the residents' health care records, reviewed the home's internal incident reports, reviewed the critical incident reports sent to the Ministry of Health and Long-Term Care (MOHLTC), reviewed various policies and procedures

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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 resident's care plan dated November 25, 2011 identified the use of floor mats while the resident is in bed and the use of a transfer belt for transferring the resident. An interview was conducted with a PSW on January 25, 2012 and they stated "doesn't use the floor mats" and "no transfer belt is used" with this resident. An interview was conducted with another PSW on January 25, 2012 and they stated that "floor mats are not used" for this resident. An interview was conducted with a PSW on January 25, 2012 and they stated "no transfer belt is used". Interview was conducted with an Registered staff member on January 25, 2012 and they stated that "residents that have a bed alarm are also to have floor mats at the bedside", as in this resident's current care plan.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007,c.8,s.6(7).]
2. A resident experienced a fall with injury that resulted in transfer to hospital for treatment in November 2011. The unwitnessed fall occurred off of the resident's unit, in a washroom outside the home's auditorium. According to the submitted Critical Incident report sent to the Ministry of Health and Long-Term Care (MOHLTC), this resident had been in the auditorium for an activity with the recreation staff when they told the staff that they were leaving and was then found in the bathroom approximately 1 hour later by a visitor who then informed the recreation staff. This resident's care plan that was in effect at the time of the incident, identified that they were a "1 prsn assist off unit". The ADON stated this "means that they are to have supervision when leaving their home unit, for safety reasons". The resident was not supervised when they left the activity in the auditorium and they subsequently attempted to toilet themselves and fell resulting in injury.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007,c.8,s.6(7).]
3. A resident experienced a fall with injury that required transfer to hospital for assessment. The fall occurred when one staff member assisted this resident from the bed to their chair with the use of a transfer pole. The progress notes from the date of the incident were reviewed for information and confirmed that the resident fell while being assisted by one staff member. The care plan that was active at the time of the fall, specified that this resident "required extensive assistance of two staff to provide physical assistance, transfer aid-transfer pole".
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007,c.8,s.6(7).]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. A resident's care plan that was in place at the time of a fall in December 2011 identified that for transfers the resident, "required extensive assistance of two staff to provide physical assistance, transfer aid-transfer pole". This resident was transferred by one staff member and the use of a transfer pole on the date of the fall despite the care plan identifying the need for two staff to provide physical assistance. The resident sustained an injury as a result of the fall and required transfer to hospital for assessment.
2. The progress notes from the date of the incident were reviewed for information and confirmed that the resident fell while being assisted by one staff member.
The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10,s.36.]

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 subsections:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. An interview was conducted with a Registered staff member on January 25, 2012 and they stated that a resident had a history of multiple falls, was known to leave the unit frequently, and was known to toilet themselves despite being a one person assist. The Registered staff member also stated that the monitoring of residents in the home include hourly checks for all residents. According to this Registered staff member, these checks are assumed to be done, and there is no place to document that this monitoring was done or to verify that it was done.
2. An interview was conducted with the ADON on January 25, 2012 and it was identified that the resident was known to go around on their own in the home unsupervised although the care plan noted that they were a "1 prsn assist off unit" which meant, for safety reasons, they are to have supervision when leaving their home unit. The ADON also stated that "the recreation staff should have notified the unit that the resident was returning and leaving the program".
3. The Policy #NSGPOL 144 with a revision date of November 2011 was to go into effect February 1, 2012. Inspector reviewed the "Falls Prevention and Management" policy that was in effect at the time of the incident and it did not include reference to the monitoring of residents.

The licensee failed to ensure that their falls prevention and management program provides for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. [O.Reg. 79/10,s.49(1).]

Issued on this 17th day of April, 2012

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