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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2019	2019_730593_0017	006769-18, 006827-18, 015214-18, 027221-18, 033715-18, 000383-19, 003279-19, 008483-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 LINDSAY ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South LINDSAY ON K9V 4R2

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

GILLIAN CHAMBERLIN (593), MARK MCGILL (733), SUSAN LUI (178)

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): May 17 - 31, 2019.

The following Critical Incident's (CIS) were inspected:

Log #006769-18 (CIS M589-000010-18) related to a fall resulting in hospitalization and a change in condition.
Log #006827-18 (CIS M589-000008-18) related to ARI outbreak declared by public health.
Log #015214-18 (CIS M589-000017-18) related to resident to resident alleged physical abuse.
Log #027221-18 (CIS M589-000003-19) related to resident to resident alleged physical abuse.
Log #033715-18 (CIS M589-000037-18) related to resident to resident alleged physical abuse.
Log #000383-19 (CIS M589-000003-19) related to resident to resident alleged physical abuse.
Log #003279-19 (CIS M589-000007-19) related to a fall resulting in hospitalization and a change in condition.
Log #008483-19 (CIS M589-000011-19) related to a fall resulting in hospitalization and a change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physiotherapist (PT), Registered Nursing Staff, Dietary Staff, Personal Support Workers (PSW) and residents.

The Inspector(s) observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records and licensee policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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	Légende 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 has failed to ensure that the care for resident #007 was provided to the resident as specified in the plan.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the fall of resident #007 resulting in hospitalization and a significant injury. It was reported in the CIS that PSW #113 was assisting resident #007 during morning care, PSW #113 left resident #007 to get the residents mobility aid, resident #007 fell backwards and landed on their buttocks.

A review of resident #007's documented plan of care found the following:

• Admission physiotherapy assessment: ambulation support status- two person assist.
• Progress note one- staff was assisting resident back from washroom during am care. Resident walking well with mobility aid and when staff member went to get the other mobility aid for resident to use, resident fell backwards to buttocks.
• Progress note dated two- resident has bruising and swelling on a specific area related to the fall from the previous day. Resident transferred to hospital.
• Progress note dated three- resident returned from hospital with the diagnosis of a significant injury.

During an interview with Inspector #593, May 29, 2019, PSW #113 indicated that they were providing resident #007's morning care, they had the resident out of bed, who ambulated with a mobility aid to the washroom and back. PSW #113 said that resident #007 indicated they would prefer to have their other mobility aid and so left them while they retrieved the other mobility aid, resident #007 fell backwards and landed on their buttocks. PSW #113 indicated that they usually used two persons for care and that one would stay with the resident, they thought that this had been changed to one person however when they checked the plan of care realized that the resident was still two

person assist. PSW #113 further added that the assist logo posted at the resident's bedside indicated two persons.

During an interview with Inspector #593, May 29, 2019, PT #120 indicated that PSW #113 should not have left resident #007 as their ambulation was two person assist and their primary mode of transport was with a specific mobility aid. The PSW was ambulating with the resident and this should have been two persons, as this was more than a transfer.

Resident #007 was assisted by one person whilst ambulating with their mobility aid, when the PSW stepped away from the resident, they fell and sustained a significant injury fracture. As such, the care related to ambulation assistance for resident #007 was not provided to the resident as specified in the plan. (log #003279-19) [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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.