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


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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'Inspection |
|---|---|---|
| Oct 19, 22, 23, 24, 26, 29, 2012 | 2012_139163_0036 | Critical Incident |

**Licensee/Titulaire de permis**

CORPORATION OF THE CITY OF TIMMINS
481 Melrose Blvd., TIMMINS, ON, P4N-5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3

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

DIANA STENLUND (163)

## 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 Nursing Care Co-ordinator, registered nursing staff, personal support workers (PSWs), and residents.**

**During the course of the inspection, the inspector(s) walked through resident home areas, reviewed health care records and home policies, observed staff to resident interactions and care.**

**During the course of the inspection, the inspector reviewed logs S-000974-12, S-001769-11, S-001887-11 and S-000228-12.**

**The following inspection Protocols were used during this inspection:**

**Falls Prevention**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident;**
**(b) the goals the care is intended to achieve; and**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has not ensured that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
Inspector reviewed the health care record of resident 974 who is reported to be at high risk for falls. Inspector noted that on October 23 and 24, 2012 resident 974 was observed to have a chair-pad alarm placed on the seat of their wheelchair. Inspector interviewed staff member S-004 on October 23, 2012 who reported that resident 974 does not require a chair-pad alarm be placed on the seat of their wheelchair. Supervisory staff member S-001 confirmed to the inspector on October 24, 2012 that resident 974 currently is required to have a chair-pad alarm in place. Inspector reviewed the health care record including the e-plan document and kardex which does not indicate the use of a chair-pad alarm. Inspector interviewed staff members S-001 and S-004 on October 23, 2012 who reported that when resident 974 is in bed, the bed is to be placed in the lowest position due to high risk for falls. Inspector reviewed the health care record for resident 974. The e-plan document and kardex do not indicate that when the resident is in bed, the bed is to be placed in the lowest position. On October 23, 2012 resident 974 was observed by the inspector to be in a high/low bed at 1555hr however the bed was not placed in the lowest position. Staff member S-001 was present when the inspector made observations at 1555hr on October 23, 2012 and confirmed that resident's 974 bed was not placed in the lowest position as required, and that the health care record does not give clear directions to staff who provide care to resident 974. Inspector observed resident 974 being transported down the hall to the dining room for breakfast on October 24, 2012 at 0835hr. Resident 974 did not have foot rests on their wheel chair while being transported or once being placed in the dining room. Inspector reviewed the health care record including the e-plan document and kardex for resident 974 which indicate the required use of foot rests on their wheel chair. Inspector interviewed supervisory staff member S-001 on October 24, 2012 who confirmed that the e-plan and kardex documents indicates the use of foot rests for resident 974, however resident 974 has been refusing to have them on their wheel chair. [LTCHA, 2007,S.O.2007, c. 8, s. 6 (c)]

***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 that for those residents at risks for falls, there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #2: 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. (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).**

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**Findings/Faits saillants :**

1. The licensee has not ensured 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.
Inspector reviewed the health care records regarding a Critical Incident where resident #228 had fallen and sustained injuries resulting in transfer to hospital. The inspector was unable to locate a post-fall assessment relating to this incident. On October 23, 2012, staff member S-001 confirmed that a post-fall assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
2. On October 23, 2012 inspector reviewed the health care records relating to a Critical Incident report regarding a fall by resident 1769 that resulted in injury and transfer to hospital . The inspector was unable to locate a post-fall assessment in the health care record for resident 1769 regarding this incident. Staff member S-001 confirmed on October 23, 2012 that a post-fall assessment pertaining to this incident was not conducted using a clinically appropriate assessment instrument that is designed for falls.
3. On October 23, 2012 inspector reviewed the health care records relating to a Critical Incident report regarding a fall by resident 974 who was documented to have a history of falls. Inspector reviewed the health care record for resident 974. A post-fall assessment was not found in the health care record for two falls which occurred. Staff member S-001 confirmed on October 23, 2012 that post-fall assessments regarding these fall incidents were not conducted on resident 974. [O. Reg. 79/10, s. 49 (2)].

***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 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, to be implemented voluntarily.***

**Issued on this 8th day of November, 2012**

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

Diana Stenlund, #163