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
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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
Jan 17, 18, 19, 27, 2012	2012_099188_0003	Complaint

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MANITOULIN LODGE
3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing staff, Personal Support Workers and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed residents' health care records, reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Reporting and Complaints

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change;
(b) the care set out in the plan is no longer necessary; or
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted that this resident was identified at a risk for falls. Inspector noted that the resident sustained a fall resulting in new interventions. Inspector noted the care plan for this resident does not identify the new interventions. The licensee failed to ensure that the care plan is reviewed and revised when the resident's care needs change. [O.Reg. 79/10, s.24(9)(a)]
2. Inspector reviewed the health care record of a resident. Inspector noted that this resident was at high risk for falls. Inspector noted new interventions were documented in the progress notes but not included in the care plan. The licensee failed to ensure that the care plan is reviewed and revised when the resident's care needs change. [O.Reg. 79/10, s.24(9)(a)
3. Inspector reviewed the health care record for a resident. Inspector noted this resident's care related to continence was changed. Inspector noted that the care plan did not reflect this change in care. The licensee failed to ensure that the care plan is reviewed and revised when the resident's care needs change. [O.Reg. 79/10, s.24(9)(a)]
4. Inspector reviewed the health care record of a resident. Inspector noted this resident required new treatment related to an injury. Inspector noted the care plan did not reflect this new treatment. The licensee failed to ensure that the care plan is reviewed and reviewed when the resident's care needs change. [O.Reg. 79/10, s.24(9)(a)]

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 residents' are reassessed and the care plan is reviewed and revised when the residents' care needs change, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted that this resident sustained a fall. Inspector reviewed the assessment section of point click care and noted that no post fall assessment was completed. Inspector spoke with Administrator who confirmed that post-fall assessment should be completed using the post fall assessment tool within point click care. The licensee failed to ensure that when a resident has fallen, the resident is assessed and 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)]
2. Inspector reviewed the health care record of a resident. Inspector noted that this resident sustained multiple falls. Inspector reviewed the assessment section of point click care for this resident and noted that no post fall assessment was completed. Inspector spoke with Administrator who identified that post-fall assessments should be completed using the post fall assessment tool within point click care. The licensee failed to ensure that when a resident has fallen, the resident is assessed and 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)]
3. Inspector reviewed the health care record of a resident. Inspector noted that this resident sustained multiple falls. Inspector noted that no post-fall assessment was completed following the falls. Inspector spoke with Administrator who confirmed after reviewed the residents electronic record on point click care, that a post fall assessment was not completed following any of the falls. The licensee failed to ensure that when a resident has fallen, the resident is assessed and 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)]

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 when a resident has fallen a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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 subsections:

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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector reviewed the health care record of a resident. Inspector noted that this resident sustained an injury requiring transfer to the hospital. Inspector reviewed the critical incident reporting system and noted no critical incident report was submitted for this injury with transfer to hospital. Inspector spoke with the home's Administrator who confirmed that a critical incident report was not submitted and the Ministry was not informed. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital. [O.Reg. 79/10, s.107(4)]
2. Inspector reviewed the health care record of a resident. Inspector noted this resident sustained an injury requiring transfer to hospital. Inspector reviewed the critical incident reporting system and noted no critical incident report was submitted for this injury with transfer to hospital. Inspector spoke with the home's Administrator who confirmed that a critical incident report was not submitted and the Ministry was not informed. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital. [O.Reg. 79/10, s.107(4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Managing Concerns/Complaints" dated September 2005 on January 17, 2012. Inspector noted this policy does not incorporate the requirements set out in the regulations. The policy fails to identify a response must be received within 10 business days and for those complaints that cannot be resolved within 10 business days, an acknowledgment of the receipt of the complaint, including the date by which the complainant can reasonably expect a resolution provided within 10 days. The policy fails to identify that the response must be provided to the person who made the complaint and include what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. The licensee failed to ensure their written complaint procedures incorporates the requirements set out in section 101 for dealing with complaints. [O.Reg. 79/10, s.100]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints
Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. Inspector noted written complaints outlining concerns about the care a resident was receiving were received by the home. Inspector was notified by the author of the complaints that a response was never received. Inspector spoke with the home's Director of Care (DOC) on January 17, 2012. The DOC confirmed a response had not been completed. The licensee failed to ensure that for every written complaint made to the licensee, concerning the care of a resident, has been investigated, resolved where possible, and a response provided within 10 business days of the receipt of the complaint. [O.Reg. 79/10, s.101(1)(1)]

Issued on this 30th day of January, 2012

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