

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

### Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

#### Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

### Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé

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

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	Licensee Copy/Copie du Titulaire Public Copy/Copie Public		
Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection	
29 and 30 March 2011	2011_127_2739_29Mar095816	Critical Incident # H-00325	
Licensee/Titulaire			
Rykka Care Centres LP, 50 Sanmore Road, Suite 205, Toronto ON M6A 1J6			
Long-Term Care Home/Foyer de soins de longue durée			
Dundurn Place Care Centre, 39 Mary Street, Hamilton ON L8R 3L8			
Name of Inspector(s)/Nom de l'inspecteur(s)			
Richard Hayden, Long Term Care Homes Inspector – Environmental Health #127			
Marilyn Tone, Long Term Care Homes Inspector – Nursing #167			
Inspection Summary / Sommaire d'inspection			
The purpose of this inspection was to inspect a critical incident related to a resident injury.			
During the course of the inspection, the inspectors spoke with the administrator, director of care and nursing staff.			
During the course of the inspection, the inspectors reviewed and made copies of a resident's plan of care and sections of the Falls Prevention Program Manual.			
The following Inspection Protocols were used during this inspection:  • Falls Prevention			
Findings of non-compliance were found during this inspection. The following action was taken:			
2 WN 2 VPC			



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#### NON-COMPLIANCE / Non-respectés

#### Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Régisseur envoye
 CO – Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue dureé à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6.(1)(c):

- 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,
  - (c) clear directions to staff and others who provide direct care to the resident.

#### Findings:

On 29 and 30 March 2011, the inspectors confirmed that an identified resident sustained an injury on after tripping on equipment that was placed next to the bed. There was no indication for the use of this equipment in the resident's plan of care on that date. The plan of care was revised two days later.

#### **Additional 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, to be implemented voluntarily, for achieving compliance with ensuring 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.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6.(8):

6.(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

#### Findings:

On 29 and 30 March 2011, the inspectors confirmed that the printed copy of the plan of care for an identified resident was not current. The plan of care was revised two months later after the resident sustained an injury. The revision directed staff to provide care differently to the resident. The new information was not included in the printed copy of the plan of care so staff who provided direct care did not have convenient or immediate access to the update.

#### **Additional 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, to be implemented voluntarily, for achieving compliance with



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ensuring the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
		A / navejni Lore
Title:	Date:	Date of Report (if different from date(s) of inspection).
		10 May 2011