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
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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
Sep 7, 12, 20, Oct 17, 2011	2011_102132_0014	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

TRUE DAVIDSON ACRES
200 DAWES ROAD, TORONTO, ON, M4C-5M8

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

ROSEMARY LAM (132)

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 Administrator, Director of Care, Nurse Manager, Registered staff, private sitter.

During the course of the inspection, the inspector(s) Review medical records, policy and procedures and observed resident in dinning room.

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	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 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. 2007, c. 8, s. 6 (8).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The plan of care for a resident was not revised when care set out in the plan has not been effective and different approaches were not considered to address resident's frequent falls and the relating contributing factors for these falls. Inspite of repeat falls, the resident's plan of care was not revised to include seat belts as per the family's request.[6.(11)(b)]
2. Other staff did not collaborate in the assessment of the resident after the resident fell. Charge nurses on the unit (RPN staff) reported only resident's minor injury found on day of the fall. Resident's change of condition on the next day were only recorded on physician's book for his review on his next visit, but were not addressed until 2 days later when the resident was send to hospital and diagnosed with fracture bone. [6(4)(a)]
3. Resident's plan of care directs staff to monitor pain from falls and to provide analgesic as needed. Pain medication (Tylenol 650mgm q6h when required) was ordered but not given to address resident's pain as result of falls on at least two occasions. [6(7)]
4. Resident's plan of care directs staff to walk resident from lounge to dinning room three time per day, inspector observed resident being wheeled from resident's room to the dinning room table at noon Sept 7, 2011.[6(7)]
5. It was confirmed that staff was unaware of the care plan's content and direction: to walk resident from Lounge to DR for meals.[6(8)]

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 sitter is aware of the plan of care for resident under his/her care; supervison is provided to ensure care as set out in the plan is provided; resident is assessed by staff and others involved in the different aspect of care and that different approaches are tried when care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 17th day of October, 2011

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