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

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 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2016	2016_333577_0003	001290-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

DEBBIE WARPULA (577)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 28, 29, 2016 and February 1, 2, 2016

The purpose of this inspection was to conduct a Complaint inspection, for logs: 034553-15, 001290-16. This inspection was conducted concurrently with Critical Incident inspection #2016_333577_0002 and Follow up inspection #2016_333577_0004.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), RAI Coordinator and residents.

Observations were made of home areas, staff and resident interactions, provision of care and services to residents, reviewed health care records, internal investigation reports, the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	Legendé 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. 138. Absences

Specifically failed to comply with the following:

s. 138. (7) A licensee of a long-term care home shall ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements is provided to the resident's health care provider during the absence. O. Reg. 79/10, s. 138 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident’s drug regime, known allergies, diagnosis and care requirements were provided to the resident’s health care provider during the absence.

In December 2015, the Ministry of Health and Long Term Care received information concerning the lack of information provided to the hospital when resident #001 was hospitalized in December 2015. Resident #001 returned to the home one day later with altered skin integrity.

A review of the home's policy, "Admissions, Transfer, Discharges and Death", last revised November 2015, indicated under the heading 'Emergency Transfer', that the nurse will send pertinent transfer information along with the resident and will retain a copy of the transfer form on the resident health record.

A review of an email dated December 2015, from the Executive Director to resident #001's family member, indicated that the home did not provide resident information specific to resident #001's required interventions and identified that the home had a gap in their transfer process.

A review of the transfer form and consolidated order form from December 2015, revealed that neither form had information concerning residents required interventions.

During an interview with RN #103 they stated that when a resident is transferred out of the home, a transfer sheet and a consolidated order sheet would be generated and they would include information regarding the resident's medication, diet, turning schedule, and current MD orders.

During an interview with the Executive Director they confirmed that the transfer form and consolidated order form did not auto-populate the information regarding a required intervention for resident #001 when they were transferred in December 2015. The Executive Director confirmed that it was the home's expectation that the transfer records contain complete information concerning the resident being transferred. [s. 138. (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 to ensure that when a resident of the home leaves for a medical absence or a psychiatric absence, information about the resident's drug regime, known allergies, diagnosis and care requirements are provided to the resident's health care provider during the absence, specifically in regards to resident #001 , to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee had failed to 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.

In December 2015, the home received a complaint email from a family member of resident #001, containing multiple areas of concern. In January 2016, the home sent an email response to the family member addressing the concerns. The email contained no specific details concerning what the licensee had done to resolve the complaint concerning a disruptive resident or if the licensee believed the complaint to be unfounded and the reasons for the belief.

In January 2016, the same family member (complainant) forwarded another complaint email to the Executive Director, requesting a response concerning a disruptive resident as they had not yet received a satisfactory response.

During an interview with the Executive Director they confirmed that a response was not given to the family member regarding what the licensee had done to resolve the complaint or if the licensee believed the complaint(s) to be unfounded and the reasons for the belief. [s. 101. (1) 1.]

Issued on this 22nd day of February, 2016

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

Original report signed by the inspector.