Ontario

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
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 5 – 7, 2011	2011_106_1159_04Jan142745	Complaint Inspection

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, ON, L5R 4B2
Fax: 289-360-1201

Long-Term Care Home/Foyer de soins de longue durée
Lakehead Manor, 135 South Vickers Street, Thunder Bay, ON, P7E 1J2
Fax : 807-623-6992

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

Margot Burns-Prouty #106

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care (DOC), the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Health Care Aids (HCA), Residents and a Substitute Decision Maker.

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed care provided to residents in the facility, audited electronic plan of care, audited written plan of care, reviewed the following:

- Bath flow sheets
- Nursing staffing schedules
- Falls prevention program
- Responsive behaviours program

The following Inspection Protocols were used in part or in whole during this inspection:

- Sufficient Staffing
- Safe and Secure Home
- Personal Support Services
- Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

9 WN
3 VPC

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, 3(1)1:
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. On January 6, 2011, a resident was observed from the hallway lying in bed uncovered in an unfastened continence care product and tee-shirt. The licensee failed to ensure that this resident was treated in a way that respected and promoted his right to be treated with courtesy and respects his dignity.

2. On January 6, 2011, a HCA was heard using the phrase "shitty" 3-4 times when conversing with other staff members in a resident lounge, in front of multiple residents to determine which resident was malodorous. The Licensee failed to ensure that the residents sitting in the resident lounge were treated in a way that respected and promoted their right to be treated with courtesy and respects their dignity.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, s. 6(10)(b):
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

Findings:

1. The licensee failed to ensure that a resident's plan of care was reviewed and revised when care set out in the plan was no longer necessary.

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WN #3: The Licensee has failed to comply with LTCHA, 2007, S. O. 2007, c. 8, 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.

Findings:

1. On January 6, 2011, a resident was not given assistance by staff to get up as stated in their plan of care. The licensee failed to ensure that the care set out in the plan of care was provided to this resident as specified in the plan.

2. On January 7, 2011, a resident was not given assistance by staff to get up as stated in their plan of care. The licensee failed to ensure that the care set out in the plan of care was provided to this resident as specified in the plan.

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WN #4: The Licensee has failed to comply with O. Reg. 79/10, s. 229(4):
The licensee shall ensure that all staff participate in the implementation of the (*infection prevention and control*) program.

Findings:

1. On January 7, 2011, an unlabeled comb was found in a bucket in the hallway on the 6th floor, containing multi-use personal care items, such as moisturizing lotion, tube of barrier cream, peri-wash spray, spray deodorant, shaving cream and mouth wash. The comb was visibly dirty. The licensee failed to ensure that all staff members participate in the implementation of the infection prevention and control program.

2. On January 7, 2011, an unlabeled comb was found in a bucket in the tub room on the 6th floor, containing multi-use personal care items, such as moisturizing lotion, tube of barrier cream, peri-wash spray, spray deodorant, shaving cream and mouth wash. The comb was visibly dirty and had multiple strands of hair in the teeth of the comb. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program

3. On January 7, 2011, a HCA on 6th floor was asked what the above mentioned unlabeled combs were used for and he stated that they were used on the residents. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program

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WN #5: The Licensee has failed to comply with O. Reg. 79/10, s. 26(3)19:
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Safety risks.

Findings:

1. On January 6, 2011 @approximately 1100, a resident was met in the stairwell. The resident stated they were going to the main floor and that they use the stair wells the when the elevator is slow. A RPN, HCA and the Administrator were questioned regarding this resident's use of the stair wells. It was found that the resident routinely uses the stairwells for exercise and as a quick mode of transport between floors. A record review of their plan of care was completed and no interdisciplinary assessment was found in regards to the safety risks that are posed with the resident using the stair wells in the home.

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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, that ensures all residents who use the stair wells have an interdisciplinary risk assessment and their written plan of care addresses how the home will ensure their safety when using the stair wells, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s. 31(2):
Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). (*Nursing and Personal Support Services*)

Findings:

1. The home was unable to produce a written staffing plan for the nursing and personal support services programs when it was requested on January 6 and 7, 2011. The licensee failed to ensure there is a written staffing plan for the nursing and personal support services programs.

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WN #7: The Licensee has failed to comply with O. Reg. 79/10, s. 33(1):
Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Findings:

1. Record reviews of bath flow sheets for a resident indicate that: The licensee failed to ensure that this resident was bathed at least twice a week.

2. A record review of bath flow sheets in various home areas for the week of December 30, 2010 to January 5, 2011, 20 residents were found to have only had one bath and 7 residents were found to have had 0 baths during that time. The licensee failed to ensure that 27 residents in various home areas were bathed at least twice during the week of December 30, 2010 to January 5, 2011.

3. A record review of bath flow sheets in various home areas for the week of December 23 to 29, 2010, 7 residents were found to have 1 bath and 2 residents were found to have had 0 baths during that time. The licensee failed to ensure that 9 residents in various home areas were bathed at least twice during the week of December 23 to 29, 2010.

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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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O. Reg. 79/10, s. 53(1)2:
Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:

1. On January 5, 2010 a review of a resident's chart showed they routinely has less than 2 baths per week. Direct care staff members (HCAs and RPN) reported to inspector 106 that the resident routinely refuses hygiene care. A record review of RAP information shows that the responsive behaviour of refusal of hygiene care is identified. No interventions to address the resident's refusal of hygiene care were found when a review of their written plan of care was completed during this inspection. The licensee failed to ensure that the written strategies for this resident include techniques and interventions, to prevent, minimize or respond to the responsive behaviour of refusal of hygiene care.

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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 the following are developed to meet this resident's needs in regards to their responsive behaviours of refusing hygiene care: Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive

behaviours, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O. Reg. 79/10, s. 91:
Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

Findings:

1. On January 5, 2011, at approximately 1215, a medication cart was found unlocked and unattended on the 5th floor. The inspector was able to gain access to the medications within the cart. The licensee failed to ensure that all hazardous substances were inaccessible to residents at all times.

2. On January 6, 2011, at approximately 1640 on the 5th floor, a medication cart was left unlocked and unattended when the RPN left the cart at the nursing station to provide care to a resident in their room. The inspector was able to gain access to the medication within the cart. The licensee failed to ensure that all hazardous substances were inaccessible to residents at all times.

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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.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** January 21, 2011