



**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**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 7, 2017	2017_652625_0008	006252-17, 006388-17, 006412-17, 006539-17	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

KATHERINE BARCA (625)

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): off-site on March 24, 2017 and on-site from March 29 to 31, 2017.

Intakes completed during this inspection were:

- log #006252-17 related to a complaint about the discharge of a resident;**
- log #006388-17 related to a complaint about alleged neglect and improper care of a resident;**
- log #006539-17 related to a complaint about alleged abuse and neglect of a resident; and**
- log #006412-17 related to a complaint about alleged abuse of a resident.**

During the course of the inspection, the inspector(s) spoke with residents, family members, a complainant, a Maintenance Helper, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN), the Associate Directors of Care (ADOCs), the Director of Care (DOC), the Business Office Manager and the Executive Director (ED).

The Inspector also reviewed resident health care records, a home's investigation file, financial records, census reports and staff schedules. The Inspector conducted observations of residents, observed the provision of services and care to residents, observed staff to resident interactions, home areas and conducted a tour of relevant resident care areas.

The following Inspection Protocols were used during this inspection:

- Admission and Discharge**
- Continence Care and Bowel Management**
- Personal Support Services**
- Prevention of Abuse, Neglect and Retaliation**
- Resident Charges**

During the course of this inspection, Non-Compliances were issued.

- 1 WN(s)**
- 1 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not discharged from the long-term care home unless permitted or required to do so by Ontario Regulation 79/10.



Ontario Regulation 79/10, s.146(4)(c) indicates that a licensee shall discharge a long-stay resident if the total length of the resident's vacation absences during the calendar year exceeds 21 days. The Regulation defines a "casual absence" to mean an absence of a resident from a long-term care home for a period not exceeding 48 hours for a purpose other than receiving medical or psychiatric care or undergoing medical or psychiatric assessment; and a "vacation absence" to mean an absence of a resident from a long-term care home for a period exceeding 48 hours for a purpose other than receiving medical or psychiatric care or undergoing medical or psychiatric assessment.

A complaint was received by the Director regarding the discharge of resident #001. The complainant indicated that the resident was discharged from the home for exceeding 21 vacation absences in a calendar year. The complainant felt that resident #001 had been wrongfully discharged.

Inspector #625 reviewed a letter dated a specific date in the spring of 2017, signed by the home's Executive Director (ED) addressed to resident #001, which indicated that the resident was discharged as per Ontario Regulation 79/10, s.146(4)(c) and that, as of that date, the resident's total vacation days away from the home exceeded 21 days.

A review of the home's Census reports for January, February and March of 2017, identified that resident #001 was absent from the home on more than 21 separate dates.

During an interview with Inspector #625 on March 31, 2017, the ED stated that the resident had been discharged because the amount of vacation absence days they had remaining in 2017 conflicted with future dates they had intended to be absent from the home. The ED stated that both they and the Associate Director of Care #101 had spoken to resident #001 and informed the resident that they may not have enough vacation absence days left as they were roughly close to having been absent for 21 vacation days in 2017.

With respect to the calculation of the number of vacation days used by resident #001, the ED acknowledged that:

- they had counted each date that the resident had been absent from the home as a vacation absence day and had not counted any of the dates as casual absences as, once the resident's time away from the home exceeded 48 hours in one week, the home had classified the entire time as a vacation absence, not just the time above the 48 hour casual absence permitted.



- the home's staff had not documented the actual times of the resident's departures and returns to the home for each absence. The ED had counted each date (including partial days) that the resident was absent from the home as a vacation absence day and did not consider the number of hours the resident was absent from the home in that calculation.
- despite a specific number of separate dates listed on the Census reports, the resident could have been absent for 48 hours or less during those dates, resulting in no vacation days being used as all absent time would have been within the 48 hours per week allowance for casual absences.

The ED and Inspector #625 reviewed the Census reports for January, February and March of 2017 and counted that the resident had been absent from the home for an approximate number of vacation days and an approximate number of casual absence days during the 2017 calendar year. The number of vacation absence days had not exceeded 21 days as was written in the discharge letter, dated a specific date in the spring of 2017, that had been issued to the resident. [s. 144.]

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 no licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by Ontario Regulation 79/10, to be implemented voluntarily.

Issued on this 7th day of April, 2017

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

Original report signed by the inspector.