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
Division de la responsabilisation et de la performance du système de santé
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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 19, 20, 21, 22, 23, 2011; Feb 22, 23, 2012	2011_051106_0016	Critical Incident

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Director of Care (DOC), Assistanct Director of care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Assistants (RCA), and residents

During the course of the inspection, the inspector(s) Conducted a walk through of resident home areas and various common areas, observed care provided to residents in the home, and reviewed resident health care records.

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

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. On September 23, 2011, a PSW told inspector 106 that a resident is independent for transfers. Inspector 106 asked the PSW where they obtained this information, the PSW stated they asked the resident how they transfer. On September 23, 2011, a RPN told inspector 106, the resident "is independent, if they need any assistance it would be supervision", in regards to the resident's transferring abilities.
2. The RAI MDS assessment, for the resident indicates they require limited assistance and one person physical assist for transfers and to walk in room and corridor. On September 20, 2011, inspector 106 asked a RPN, how staff that do not have access to the computer system, access resident plans of care. The RPN showed inspector 106, a binder where the written plans of care are kept. On September 23, 2011 there was no plan of care or 24-hour admission plan of care for the resident in the plan of care binder. The licensee failed to ensure that 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. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (8)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. On September 22, 2011 at 1106 hours, inspector 106 observed, a resident asleep in bed, their call bell was on the floor near head of the bed and not accessible to the resident. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
2. On September 22, 2011 at 1103 hours, inspector 106 observed a resident asleep in bed. The resident's call bell was on the floor near the head of the bed and not accessible to the resident. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
3. On September 23, 2011 at 1327 hours, inspector 106 observed a resident sitting in their wheelchair in their room. The resident's call bell was wrapped around the side rail that was in the down position and was not easily accessible to the resident. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)

Issued on this 24th day of February, 2012

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