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
Mar 2, May 21, 22, 23, 2012	2012_104196_0009	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

LAUREN TENHUNEN (196)

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 the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents, reviewed the resident's health care record, reviewed the Critical Incident report that was submitted to the Ministry of Health and Long-Term Care (MOHLTC)

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (10) 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Inspector reviewed the health care records for resident #001. The progress notes identified that the resident had a fall on one day and was sent to hospital the following day for assessment. The resident returned to the home that same day and according to the progress notes over the course of approximately nine days, the resident continued to exhibit varying degrees of pain in the left hip and leg and had difficulty weight bearing. The resident was sent again to the hospital for further assessment and it was identified that they had a fracture. The resident was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed.
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007, S.O.2007,c. 8, s. 6 (10)(b).]
2. Inspector reviewed the health care records for resident #001. The care plan with the focus of dressing and mobility included the intervention of "padors to be worn when up" and "ensure padors are worn at all times when up ambulating for safety and comfort". Interview was conducted with the DOC on March 2, 2012 and it was determined that hip protectors/padors had not been in use at the home. The care plan specified that hip protectors/padors were to be worn by the resident but it was identified by the DOC that they were not used.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O.2007,c. 8, s. 6 (7).]
3. Inspector reviewed the health care records for resident #001. The care plan with the focus of falls included the intervention of "place resident on the Falls Intervention Risk Management(FIRM)". Interview was conducted with the DOC on March 2, 2012 and it was determined that the term "FIRM" refers to the strategies and management for fall prevention. Interviews were conducted with a total of four staff members and these direct care staff were unable to identify what the term "FIRM" referred to. The written plan of care for resident #001 did not give clear directions to those staff that provide direct care, specifically did not outline strategies and management for fall prevention.
The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007,c. 8, s. 6 (1)(c).]

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 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, that the care set out in the plan of care is provided to the resident as specified in the plan,and that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. A Critical Incident report was submitted to the MOHLTC on January 30, 2012 for a resident fall with injury and subsequent transfer to hospital. The fall had occurred several days prior to this date and the home had not notified the MOHLTC within one business day of the incident, as is required. The inspector conducted an interview with the DOC on March 2, 2012 and it was confirmed that the home had not informed the Director of the incident in the required time frame.
The licensee did not ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital. [O. Reg. 79/10, s. 107 (3)4.]

Issued on this 23rd day of May, 2012

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

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