Ministry of Health and Long-Term Care

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**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**

## Public Copy/Copie du public

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| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LAUREN TENHUNEN (196) |
| **Inspection No. / No de l'inspection :** | 2013_104196_0002 |
| **Log No. / Registre no:** | S-001372-12 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 3, 2013 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | LAKEHEAD MANOR<br>135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | ~~SHELEIGH MCMILLAN~~ JONATHON RIABOV |

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

The licensee shall ensure that steps are taken to identify and implement interventions to minimize the risk of altercations and potentially harmful interactions between resident #002 and #001.

**Grounds / Motifs :**

1. Resident #002 was initially admitted into the home into a semi private room without a room mate. Subsequently, resident #001 was admitted to the home and became a room mate to resident #002.

Further to that, a Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) outlining an altercation in which resident #002 grabbed and pushed resident #001 to the floor, resulting in injury and transfer to hospital.

The health care record for resident #002 was reviewed. The progress notes, from the day prior to receiving a room mate, identified that resident #002 was "concerned with the shared space". The progress notes from another day, noted that resident #002 was upset towards their room mate, and five days later noted that resident may benefit from own room. Just prior to the incident, resident #002's progress notes identified that they are "territorial, telling room mate what (they) can and can not do, insisting room light is on..."
The progress notes for resident "#001, nine days after admission, stated "...state

(they) afraid of (their) roommate they been arguing during the night and most of the day will continue to monitor behaviour".
Inspector conducted an interview during the inspection, with management staff member #100 and it was reported that resident #002 had demonstrated increasing responsive behaviours after receiving a room mate and also that the resident would hold the door shut and not let resident #001 into the room and would verbally tell (them) to get out of (their) room.

Despite resident #002's documented behaviours, through to the day of the altercation and resident #001's expressions of fear, there were no interventions identified nor implemented to minimize the risk of altercations between resident #002 and #001.

The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

(196)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 28, 2013

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 3rd day of June, 2013**

**Signature of Inspector / Signature de l'inspecteur :** Lauren Tenhunen #196.

**Name of Inspector / Nom de l'inspecteur :** Lauren Tenhunen

**Service Area Office / Bureau régional de services :** Sudbury Service Area Office

**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 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 3, 2013 | 2013_104196_0002 | S-001372-12 | Critical Incident System |

**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 Critical Incident System inspection.**

**This inspection was conducted on the following date(s): January 11 and 22, 2013**

**Ministry of Health and Long-Term Care (MOHLTC) Log
Critical Incident report**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Service Coordinator, RAI Coordinator, Residents**

**During the course of the inspection, the inspector(s) conducted a walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of several residents, reviewed the registered nursing staff schedule**

**The following Inspection Protocols were used during this inspection:
Responsive Behaviours**

**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 54. Altercations and other interactions between residents**

**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**

**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**

**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

Resident #002 was initially admitted into the home into a semi private room without a room mate. Subsequently, resident #001 was admitted to the home and became a room mate to resident #002.

Further to that, a Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) outlining an altercation in which resident #002 grabbed and pushed resident #001 to the floor, resulting in injury and transfer to hospital.

The health care record for resident #002 was reviewed. The progress notes, from the day prior to receiving a room mate, identified that resident #002 was "concerned with the shared space". The progress notes from another day, noted that resident #002 was upset towards their room mate, and five days later noted that resident may benefit from own room. Just prior to the incident, resident #002's progress notes identified that they are "territorial, telling room mate what (they) can and can not do, insisting room light is on..."
The progress notes for resident "#001, nine days after admission, stated "...state (they) afraid of (their) roommate they been arguing during the night and most of the day will continue to monitor behaviour".
Inspector conducted an interview during the inspection, with management staff member #100 and it was reported that resident #002 had demonstrated increasing responsive behaviours after receiving a room mate and also that the resident would hold the door shut and not let resident #001 into the room and would verbally tell (them) to get out of (their) room.

Despite resident #002's documented behaviours, through to the day of the altercation and resident #001's expressions of fear, there were no interventions identified nor implemented to minimize the risk of altercations between resident #002 and #001.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions. [s. 54. (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

On January 22, 2013, an interview was conducted with management staff member #100 regarding the Registered Nurse (RN) staffing in the home. It was reported that the home had been short three full-time RNs over the previous few months and as a result, an agency RN had been brought in from Toronto to cover these shifts and this position ended January 11, 2013. In addition, it was reported that over the previous few weeks there had been shifts in which there was no RN on duty and present in the home, as a result of sick calls by the RN's that were scheduled to work, but that a RN would be on call and available by telephone. Management staff member #100 reported there was no RN on duty and present in the home on the night shift of January 19, evening and night shift of January 20, and the day shift of January 13, 2013.

The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. [s. 8. (3)]

***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 will ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

A Critical Incident report was submitted to the MOHLTC outlining an altercation between resident #001 and #002. The plan of care that was in effect at the time of the incident was reviewed and did not identify resident #002's responsive behaviours and potential behavioural triggers, despite progress notes that identified responsive behaviours were present and occurring.

The licensee failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

***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 resident #002's plan of care is based on, at a minimum, mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**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. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

During the course of the inspection, the inspector conducted an interview with staff member #101 and it was reported that there was concern with the staffing levels throughout the home and that the staff are not able to get everything done for the residents, as is required. It was reported that on a particular day in January 2013, one unit was short-staffed by one PSW and residents #003 and #004 did not receive their tub baths as per the bath schedule and instead received bed baths. Staff member #101 also reported that an extra PSW was scheduled for the following day to complete the missed baths but was required to work elsewhere in the home. The health care records of both residents were reviewed and it was determined that resident #003 is incontinent of both bowel and bladder and resident #004 is continent of bowel, but is incontinent of bladder on all shifts on occasion. Inspector reviewed the bath schedule and noted both of these residents were to receive a tub bath on Monday mornings and again on Thursday mornings.
It was determined, after a review of the bath schedule, that from January 1 through to January 21, 2013, both residents #003 and #004 were to have a total of six tub baths (two baths per week X 3 weeks). A review of the flow sheets was completed and resident #004 had 3 documented baths, that included one bed bath and two tub baths and resident #003 had 2 documented baths, that included one bed bath and one tub bath. No refusals, related to bathing, were noted during this time period. In addition, the RAI MDS coding for all shifts during this same time period, that did not have either a tub bath or a bed bath recorded, was coded "8" for the activity of "bathing - Activity did not occur".

According to the flow sheet documentation for residents #003 and #004, neither resident was bathed a minimum of twice a week by the method of his or her choice, during the time period of January 1 to January 21, 2013.

The licensee failed 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. [s. 33. (1)]

*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 resident #003 and resident #004 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

Resident #002 was initially admitted into the home into a semi private room without a room mate. Subsequently, resident #001 was admitted to the home and became a room mate to resident #002.

Further to that, a Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) outlining an altercation in which resident #002 grabbed and pushed resident #001 to the floor, resulting in injury and transfer to hospital.

The health care record for resident #002 was reviewed. The progress notes, from the day prior to receiving a room mate, identified that resident #002 was "concerned with the shared space". The progress notes from another day, noted that resident #002 was upset towards their room mate, and five days later noted that resident may benefit from own room. Just prior to the incident, resident #002's progress notes identified that they are "territorial, telling room mate what (they) can and can not do, insisting room light is on..."
The progress notes for resident "#001, nine days after admission, stated "...state (they) afraid of (their) roommate they been arguing during the night and most of the day will continue to monitor behaviour".
Inspector conducted an interview during the inspection, with management staff member #100 and it was reported that resident #002 had demonstrated increasing responsive behaviours after receiving a room mate and also that the resident would hold the door shut and not let resident #001 into the room and would verbally tell (them) to get out of (their) room.
Resident #002 was demonstrating responsive behaviours from the day prior to receiving a room mate through to the date of the altercation, specifically relating to having a room mate, and there was no documentation of the actions that were taken to respond to this resident needs, no assessments, reassessments or interventions noted until after an altercation had occurred.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. [s. 53. (4) (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 the actions that are taken to respond to the needs of resident #002, including assessments, reassessments and interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

During the course of the inspection, the inspector observed resident #003 sitting in a chair in the common TV room on one of the home's units. The seating surface of the chair was soiled with a large amount of dried food debris and other unknown dried debris.

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

Issued on this 4th day of June, 2013

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
| --- |
| Lauren Tenhunen #196. |