



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**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

**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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<b>Name of Inspector (ID #) / Nom de l'inspecteur (No) :</b>	DIANA STENLUND (163)
<b>Inspection No. / No de l'inspection :</b>	2012_139163_0002
<b>Type of Inspection / Genre d'inspection:</b>	Complaint
<b>Date of Inspection / Date de l'inspection :</b>	Feb 16, 21, 22, 23, 24, 29, 2012
<b>Licensee / Titulaire de permis :</b>	BOARD OF MANAGEMENT FOR THE DISTRICT OF ALGOMA 135 Dawson Street, ALGOMA, ON, P0R-1L0
<b>LTC Home / Foyer de SLD :</b>	ALGOMA DISTRICT HOMES FOR THE AGED 135 DAWSON STREET, THESSALON, ON, P0R-1L0
<b>Name of Administrator / Nom de l'administratrice ou de l'administrateur :</b>	BARBARA HARTEN

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To BOARD OF MANAGEMENT FOR THE DISTRICT OF ALGOMA, you are hereby required to comply with the following order(s) by the date(s) set out below:



**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*

**Ministère 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*

**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that a nutrition manager (NM) is on site working in the capacity of a NM for the minimum number of hours per week calculated under section (4), without including any hours spent fulfilling other responsibilities.

The plan shall be submitted to Diana Stenlund, Ministry of Health and Long-Term Care, Performance and Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury ON P3E 6A5 by March 15, 2012.

**Grounds / Motifs :**

1. The inspector interviewed a Specialty Care Consultant on February 16, 2012. It was reported to the inspector "there is still no nutrition manager since the nutrition manager left in June 2011; a dietary person (aide) is the lead currently. The dietary consultant from Specialty Care has covered intermittently, however this person has not been back here since December 2011." (163)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2012



**Ministry of Health and  
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**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  
55 St. Clair Avenue West  
Suite 800, 8th Floor  
Toronto, ON M4V 2Y2  
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  
55 St. Clair Avenue West  
Suite 800, 8th Floor  
Toronto, ON M4V 2Y2  
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](http://www.hsarb.on.ca).



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**Ordre(s) de l'inspecteur**  
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**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  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 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  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 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](http://www.hsarb.on.ca).

**Issued on this 29th day of February, 2012**

**Signature of Inspector /  
Signature de l'inspecteur :**

*Diana Stenlund # 1163*

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

DIANA STENLUND

**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 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
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

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Feb 16, 21, 22, 23, 24, 29, 2012; 2012\_139163\_0002; Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT FOR THE DISTRICT OF ALGOMA
135 Dawson Street, ALGOMA, ON, POR-1L0

Long-Term Care Home/Foyer de soins de longue durée

ALGOMA DISTRICT HOMES FOR THE AGED
135 DAWSON STREET, THESSALON, ON, POR-1L0

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

DIANA STENLUND (163)

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 a consultant from Specialty Care, the Director of Care (DOC), registered staff, personal support workers (PSWs), residents, and family members.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed health care records, reviewed home policies and procedures and observed resident care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

<b>Legend</b>  WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	<b>Legendé</b>  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 O.Reg 79/10, s. 75. Nutrition manager  
Specifically failed to comply with the following subsections:**

**s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a nutrition manager is on site at the home working in the capacity of a nutrition manager for the minimum number of hours per week calculated under subsection (4) without including any hours spent fulfilling other responsibilities.

The inspector interviewed a Specialty Care Consultant on February 16, 2012. "There is still no nutrition manager since the nutrition manager left in June 2011, there is a dietary lead." The Specialty Care Consultant added "the dietary consultant from Specialty Care has covered however has not been back here since December 2011. They consult from afar, with the dietary lead but does not take over the department." [O.Reg.79/10,s75(3)]

**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 O.Reg 79/10, s. 48. Required programs  
Specifically failed to comply with the following subsections:**

**s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,  
(a) provide for screening protocols; and  
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).**

**Findings/Faits saillants :**

1. The licensee has not ensured that the home's Continence Care Program provides for assessment instruments specifically designed for the assessment of incontinence. The inspector interviewed two registered nurses (RNs). One RN was interviewed on February 16, 2012 and the other RN on February 21, 2012. They confirmed that the home does not currently use an assessment instrument that is specifically designed for assessing incontinence and that the home has not used one for the last two to three years. [O.Reg.s.48(2)(b)]

**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 the home's Continence Care Program provides for assessment instruments specifically designed for the assessment of incontinence, to be implemented voluntarily.*

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**  
Specifically failed to comply with the following subsections:

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident has fallen the resident has been assessed and if required a post-falls assessment has been conducted using a clinically appropriate assessment instrument that is specially designed for falls.

The inspector reviewed the health care records of three residents with a falls history. A post falls assessment was not located by the inspector for any of the three residents.

The inspector interviewed a RN, on February 21, 2012. It was reported to the inspector "we use a falls risk assessment but we don't have a post-falls assessment".

A Specialty Care Consultant was interviewed on February 16, 2012 who reported "we currently do not have a post-falls assessment, we use a falls risk assessment right now". [O.Reg. 79/10,s.49(2)]

**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 a when a resident has fallen, the resident is assessed using a clinically appropriate post-falls assessment that is specifically designed for falls, to be implemented voluntarily.*

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**  
Specifically failed to comply with the following subsections:

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a policy that under the Falls Management Program has been complied with by staff.

The inspector interviewed the Director of Care (DOC), on February 22, 2012 about a resident who fell in the home in the month of January 2012 and sustained a fracture. The home's Fall Prevention and Management - Falls Risk Factors & Related Interventions Policy (V1-G-60.00) indicates for registered staff "If there is a suspicion or evidence of injury the resident should not be moved. The physician should be contacted, and/or arrange for immediate transfer to the hospital". The DOC reported that the resident who had fallen in this incident complained of pain right after the fall, the resident's leg was externally rotated and was unable to weight bear, however the RPN on the unit who assessed the resident placed the resident in a wheel chair. The DOC added that the RPN did not report the full extent of the resident's injury to the charge nurse on days, and as a result, the resident was not assessed until when the evening RN came on shift and assessed the resident later that evening. It was then determined by the evening RN that the resident be sent to the hospital for assessment.

Physician examination notes related to this resident's injury: "fell this afternoon, pain Rt hip, unable to weight bear. Injury not reported to MD until this evening." [O.Reg.79/10,s8(1)(b)]

**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 home's staff comply with the home's policy "Falls Prevention and Management - Falls Risk Factors & Related Interventions", to be implemented voluntarily.**

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**WN #5: 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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an incident in respect of which a person is injured and taken to hospital.

A resident sustained a fall in the month of January 2012 and was taken to hospital the same day as a result of their injuries. In an interview with the Director of Care (DOC) on February 22, 2012, it was reported to the inspector that the Director was not informed until four days after the incident.

Review of the Critical Incident report confirmed the specific date of the resident's injury in the month of January 2012 and that it was not reported to the Director until four days later. [O.Reg. 79/10,s.107(3)4]





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  
prévus le Loi de 2007 les  
foyers de soins de longue

Issued on this 21st day of March, 2012

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

*Diana Stenlund, #163*