

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
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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 |
|--|-----------------------------------|---------------------------------------|
| Oct 21, Nov 7, 8, 2011; Jan 11, 2012   | 2011_065169_0023                  | Critical Incident                     |
| Licensee/Titulaire de permis   |                                   |                                       |
| CITY OF HAMILTON 77 James Street North, Suite 400, HAMI Long-Term Care Home/Foyer de soins |                                   |                                       |
| MACASSA LODGE<br>701 UPPER SHERMAN AVENUE, HAM   | IILTON, ON, L8V-3M7               |                                       |
| Name of Inspector(s)/Nom de l'inspec   | teur ou des inspecteurs           |                                       |
| YVONNE WALTON (169)  |                                   |                                       |
| lnsı   | pection Summary/Résumé de l'inspe | ection                                |

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

During the course of the inspection, the inspector(s) spoke with Director of Nursing, Nurse Managers and nursing staff.

During the course of the inspection, the inspector(s) conducted a clinical health review, observed care, reviewed policies and procedures.

The following Inspection Protocols were used during this inspection: Falls Prevention

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON          | I-RESPECT DES EXIGENCES   |
|-------------------------------|---|
|                               | Legendé  WN - Avis écrit  VPC - Plan de redressement volontaire |
|                               |   |
| DR - Director Referral        | DR = Alguillage au directeur                                    |
| CO – Compliance Order         | CO = Ordre de conformité  |
| WAO – Work and Activity Order | WAO - Ordres : travaux et activités                             |



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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).

## Findings/Faits saillants:

1. The written plan of care does not provide clear directions to staff and others who provide direct care for an identified resident. The mobility directions identified in the resident's written plan of care do not include the use of specific mobility devices. The written plan of care does not identify the level of assistance or supervision required by the resident to safely mobilize. The plan of care was reviewed with the nursing staff and they confirmed the lack of clear direction.

Issued on this 11th day of January, 2012

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

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