Ontario

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2012_140158_0025
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Nov 8, 9, 12, Dec 10, 11, 2012
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jo-Anne Palkovits

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2012_139163_0010, CO #001

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee will ensure that procedures and interventions to manage resident # 01 aggressive behaviours are developed and implemented so that, the risk of altercations and harmful interactions between resident # 01 and any resident, including Resident # 02 is prevented and that procedures and interventions to manage resident # 02 aggressive behaviours are developed and implemented so that, the risk of altercations and harmful interactions between resident # 01 and resident # 02 is prevented.

Grounds / Motifs :

1. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents [O. Reg. 79/10, s. 55. (a)]
The health care record, including the progress notes, the MDS assessment and the care plan for resident # 02 was reviewed by the Inspector on November 7 and 8, 2012.
In September 2012, staff # S-100 documented in the progress notes that resident # 02 had an altercation with resident # 01 and that resident # 02 stated that they are tired of nothing being done and is taking things into their own hands.
A Mandatory Incident Report identifying the physical altercation between resident # 01 and resident # 02 was reported to the Director in September 2012. It was documented on the home's Internal Incident Report, that there is a long standing animosity between resident # 01 and resident # 02, who had previously shared a wash room. The report also identified that resident # 02 was responsible for causing injury to resident # 01 during an altercation in September 2012, when resident # 01 hit resident # 02.
Staff # S-102 documented in resident # 02 progress notes in October 2012, that an altercation between resident # 02 and resident # 01 occurred and that resident # 02 stated that they were fed up and if this continues, they would be going to jail because of what they might do to resident # 01.
It was documented by staff S-103, 11 days later that a second altercation between resident # 01 and resident # 02 occurred in October 2012.
Three days after the second altercation, staff # S-104 documented that when they met with resident # 02 and resident # 01 to discuss ongoing issues, an agreement to be civil and ignore the behaviours was made.
Resident # 02 care plan was reviewed by the Inspector and although the care plan identifies the resident's verbal/ physical aggression and anger, the interventions are generic and do not identify the past altercations, the witnessed assault or the continued animosity between resident # 01 and resident # 02. Interventions have not been developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a

result of resident # 02 behaviours or to minimize the risk of altercations and potentially harmful interactions between resident # 01 and resident # 02. [O. Reg. 79/10, s. 55. (a)] (158)

2. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The health care record, including the progress notes, MDS assessments, senior's mental health assessment and the care plan for resident # 01 was reviewed by the Inspector on November 8 and 9, 2012.

There are numerous documented accounts in the progress notes, dating back to August 2012 of resident # 01 being verbally aggressive, using threatening gestures and being physically aggressive to other residents. A critical incident was submitted to the MOHLTC, identifying that resident # 01 sustained injury after an altercation with resident # 02.

The Inspector reviewed the October 2012 MDS assessment and the care plan for resident # 01 with staff # S-107 on November 9, 2012. The October 2012 MDS assessment identified that resident # 01 displays anger with others which is not easily altered, however, the care plan does not address this. The care plan does identify verbal aggression towards staff or when there is a change in routine but verbal and physical aggression towards other residents, resident # 01 denial of responsibility of their aggressive actions, and recent altercations with other residents, including resident # 02 is not identified.

Staff # S-107 stated to the Inspector that every 15 minute checks are being conducted by staff as resident # 01 has been taunting their new roommate. On November 9, 2012, the Inspector spoke with staff # S-105 and staff # S-106, who both stated that they were not aware of this intervention. When asked whether there were any issues between the 2 residents or if resident # 01 was displaying aggressive actions toward the roommate, they each replied that there were no issues between the 2 residents.

The Inspector reviewed the home's policy "Responsive Behaviours" which states that the plan of care for residents with responsive behaviours addresses the strategies and procedures to minimize the risk of altercations. There are no procedures or interventions written in resident # 01 care plan to manage the resident's verbal or physical aggression or interventions to manage or prevent altercations. [O. Reg. 79/10, s. 55. (a)] (158)

3. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. It was identified to the Inspector during an interview with staff # S-108 and staff # S-109 that a shift report which includes information about residents that require monitoring is to be printed at the end of every shift and placed in the shift binder for easy access for staff. A review of one unit's shift report binder with staff # S -109, showed that several shift reports were not placed in the binder as per the home's required procedure for the previous week. Staff # S-109 identified that one of this unit's shift report, is kept in a different unit's binder. Upon review of the other unit's report binder, the Inspector did not find any reports. The home's corrective action plan, which was submitted for C/O 001, issued during the Inspection # 2012_099188-0001 and the Follow -Up Inspection # 2012_139163_0010 identified that the home would ensure continued compliance with the Shift Report process. The home has failed to ensure compliance with the shift report process. [Reg. 79/10, s. 55. (a)] (158)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 10, 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
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

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

Director

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.

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.

Issued on this 11th day of December, 2012

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

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
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

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 8, 9, 12, Dec 10, 11, 2012	2012_140158_0025	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the the home's Site Administrator, the Assistant Director of Care (ADOC), Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), residents and visitors.

During the course of the inspection, the inspector(s) completed a walk through of resident care areas, observed staff to resident interactions, reviewed residents' health care records, and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. It was identified to the Inspector during an interview with staff # S-108 and staff # S-109 that a shift report which includes information about residents that require monitoring is to be printed at the end of every shift and placed in the shift binder for easy access for staff. A review of one unit's shift report binder with staff # S-109, showed that several shift reports were not placed in the binder as per the home's required procedure for the previous week. Staff # S-109 identified that one of this unit's shift report, is kept in a different unit's binder. Upon review of the other unit's report binder, the Inspector did not find any reports. The home's corrective action plan, which was submitted for C/O 001, issued during the Inspection # 2012_099188-0001 and the Follow -Up Inspection # 2012_139163_0010 identified that the home would ensure continued compliance with the Shift Report process. The home has failed to ensure compliance with the shift report process. [Reg. 79/10, s. 55. (a)]

2. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The health care record, including the progress notes, MDS assessments, senior's mental health assessment and the care plan for resident # 01 was reviewed by the Inspector on November 8 and 9, 2012.

There are numerous documented accounts in the progress notes, dating back to August 2012 of resident # 01 being verbally aggressive, using threatening gestures and being physically aggressive to other residents. A critical incident was submitted to the MOHLTC, identifying that resident # 01 sustained injury after an altercation with resident # 02.

The Inspector reviewed the October 2012 MDS assessment and the care plan for resident # 01 with staff # S-107 on November 9, 2012. The October 2012 MDS assessment identified that resident # 01 displays anger with others which is not easily altered, however, the care plan does not address this. The care plan does identify verbal aggression towards staff or when there is a change in routine but verbal and physical aggression towards other residents, resident # 01 denial of responsibility of their aggressive actions, and recent altercations with other residents, including resident # 02 is not identified.

Staff # S-107 stated to the Inspector that every 15 minute checks are being conducted by staff as resident # 01 has been taunting their new roommate. On November 9, 2012, the Inspector spoke with staff # S-105 and staff # S-106, who both stated that they were not aware of this intervention. When asked whether there were any issues between the 2 residents or if resident # 01 was displaying aggressive actions toward the roommate, they each replied that there were no issues between the 2 residents.

The Inspector reviewed the home's policy "Responsive Behaviours" which states that the plan of care for residents with responsive behaviours addresses the strategies and procedures to minimize the risk of altercations. There are no procedures or interventions written in resident # 01 care plan to manage the resident's verbal or physical aggression or interventions to manage or prevent altercations. [O. Reg. 79/10, s. 55. (a)]

3. The licensee did not ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents [O. Reg. 79/10, s. 55. (a)]

The health care record, including the progress notes, the MDS assessment and the care plan for resident # 02 was reviewed by the Inspector on November 7 and 8, 2012.

In September 2012, staff # S-100 documented in the progress notes that resident # 02 had an altercation with resident # 01 and that resident # 02 stated that they are tired of nothing being done and is taking things into their own hands.

A Mandatory Incident Report identifying the physical altercation between resident # 01 and resident # 02 was reported to the Director in September 2012. It was documented on the home's Internal Incident Report, that there is a long standing animosity between resident # 01 and resident # 02, who had previously shared a wash room. The report also identified that resident # 02 was responsible for causing injury to resident # 01 during an altercation in September 2012, when resident # 01 hit resident # 02.

Staff # S-102 documented in resident # 02 progress notes in October 2012, that an altercation between resident # 02 and resident # 01 occurred and that resident # 02 stated that they were fed up and if this continues, they would be going to jail because of what they might do to resident # 01.

It was documented by staff S-103, 11 days later that a second altercation between resident # 01 and resident # 02 occurred in October 2012.

Three days after the second altercation. staff # S-104 documented that when they met with resident # 02 and resident #

01 to discuss ongoing issues, an agreement to be civil and ignore the behaviours was made.
Resident # 02 care plan was reviewed by the Inspector and although the care plan identifies the resident's verbal/ physical aggression and anger, the interventions are generic and do not identify the past altercations, the witnessed assault or the continued animosity between resident # 01 and resident # 02. Interventions have not been developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident # 02 behaviours or to minimize the risk of altercations and potentially harmful interactions between resident # 01 and resident # 02. [O. Reg. 79/10, s. 55. (a)]

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. 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. (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. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. The Inspector reviewed the October 2012 MDS assessment and the plan of care for resident # 01 with staff # S-107 on November 9, 2012. The October 2012 MDS assessment identified that resident # 01 displays anger with others which is not easily altered, however, the care plan does not identify this. The care plan does identify verbal aggression towards staff or when there is a change in routine but verbal and physical aggression towards other residents, resident # 01 denial of responsibility of their aggressive actions, and recent altercations with other residents, including resident # 02 is not identified.Clear direction to staff and others to manage resident # 01 responsive behaviour is not set out in the plan of care.
2. The health care record, including the progress notes and the care plan for resident # 06 was reviewed by Inspector on November 9, 2012. In November 2012, staff # S-110 documented on two separate occasions in resident # 06 progress notes that the resident was exit seeking and saying "I would like to check-out now". In November 2012, staff # S-111 documented a third incident when resident # 06 was exit seeking and wandering during a shift.
Seven days prior to the third incident, staff # S-111 documented that resident # 06 was exit seeking, wandering, and asking how to leave the unit during one shift. It was also documented that the resident was successful in eloping off the unit during the shift. Resident # 06 care plan identified, under anxiety, that the resident wanted to go home, however, the care plan did not address the resident's exit seeking behaviour, nor identify interventions to manage the behaviour. The plan of care did not set out clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1) (c)]
3. On November 9, 2012, the Inspector observed that a chair alarm was in place and that the alarm did ring when resident # 07 attempted to stand and became unsteady on their feet. The health care record, including the plan of care and progress notes for resident # 07 was reviewed by the Inspector on November 7, 2012. The resident's progress notes identified that the resident had previously fallen several times, as a result of self transferring. Although, resident # 07 care plan has fall prevention interventions written, the use of the chair alarm is not documented in the plan. The plan of care did not set out clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1) (c)]
4. Staff and others who provide direct care to the resident did not have convenient and immediate access to resident # 02 plan of care. On November 7, 2012, the Inspector could not locate resident # 02 written care plan.
All care plan books were reviewed and resident # 02 written care plan was not found. Staff S-112 and Staff # S-113 identified that the resident was transferred to the unit a month ago and that the care plan should have been in the care plan binder. Both confirmed that the PSW use the binders as a primary source of information. The licensee did not 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. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (8)]

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 ensuring that the plan of care sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

Issued on this 11th day of December, 2012

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