Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2016	2016_264609_0009	030313-15	Complaint

Licensee/Titulaire de permis

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 1, 2, 3, 2016.

This inspection was completed as a result of a complaint submitted to the Director related to staff and resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Medical Director, the Director of Care (DOC), the Director of Resident Services, Registered Nurses and Registered Practical Nurses (RNs, RPNs) as well as Recreational staff.

The inspector(s) also toured the home daily, observed staff and resident interactions, reviewed policies and procedures, clinical records, internal investigation reports, components of human resource files and training logs.

Ad-hoc notes were used during this inspection.

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director which alleged the provision of care given by staff was not according to the resident's plan of care.

A review of the clinical record for an identified resident revealed that on an defined day in order to manage responsive behaviours, a specified intervention was initiated and the plan of care for the identified resident was updated.

The identified resident had an active SDM for care.

An interview with registered staff revealed they did not notify or obtain consent from the SDM prior to initiating the specified intervention or revising the the identified resident's plan of care.

An interview with the DOC confirmed that it was the expectation of the home that the active SDM for a resident would have been provided the opportunity to participate fully in the development and implementation of the plan of care.

The DOC confirmed that in the case of initiating the specified intervention and updating the plan of care for the identified resident prior to obtaining consent from their SDM, the home was not in compliance with the Act and should have been. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care provided to the resident was as specified in the plan.

A complaint was submitted to the Director which alleged the provision of care given by staff was not according to the resident's plan of care.

An interview with medical staff revealed that in two separate incidents an identified resident was provided a specified intervention despite a physician's order to the contrary.

A review of the clinical record revealed a physician's order was issued that clearly identified to staff not to provide the specified intervention.

A review of the plan of care for the identified resident also revealed clear direction to staff, not to provide the specified intervention.

An interview with the staff member implicated in the complaint confirmed they provided the specified intervention on more than one occasion despite their awareness not to provide the specified intervention.

An interview with the DOC confirmed that it was the expectation of the home that the care set out in the plan of care was to have been provided as specified in the plan.

The DOC confirmed that in the case of the staff member who provided a specified intervention that was contrary to the resident's plan, the home was not in compliance with the Act and should have been. [s. 6. (7)]

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 resident's Substitute Decision Maker (SDM) is provided the opportunity to participate fully in the development and implementation of the plan of care as well as to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 28th day of April, 2016

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

Original report signed by the inspector.