Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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
Facsimilie: 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

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
November 14 – 17, 2010	2010_106_9513_15Nov161740	Critical Incident Report Inspection Log# S-00152

Licensee/Titulaire
The Corporation of the City of Thunder Bay, c/o Dawson Court, 523 Algoma Street North, Thunder Bay, ON, P7A 5C2
Fax: 807-345-8854

Long-Term Care Home/Foyer de soins de longue durée
Dawson Court, 523 North Algoma Street, Thunder Bay , ON , P7A 5C2
Fax : 807-345-8854

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

Margot Burns-Prouty #106

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct three inspections concurrently, a complaint inspection and 2 critical incident report inspections.

During the course of the inspection, the inspector spoke with:

- the Administrator,
- the Director of Care (DOC),
- Environmental Services Manager
- Registered Nurses
- Registered Practical Nurses,
- Health Care Aids (HCA),
- Resident
- Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s):

- Conducted a walk-through of all resident home areas and various common areas,
- observed care provided to residents in the facility,
- Interviewed staff members
- Interviewed resident/SDM
- audited electronic and written plans of care,
- reviewed the following:
  - Falls Prevention policies
  - Responsive Behaviour policies

The following Inspection Protocols were used in part or in whole during this inspection:

- Personal Support Services
- Falls Prevention
- Responsive Behaviours

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Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg 79/10, s. 53(4)(b):

The licensee shall ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible;

Findings:

1. The plan of care for a resident does not have any strategies in place that provide for monitoring and recording when the resident exhibits responsive behaviours. The licensee failed to ensure that strategies have been developed and implemented to respond to this resident's responsive behaviour.

2. A review of a resident's progress notes show that staff are not documenting that the resident's responsive behaviour when completing their hourly checks of residents as per the home policy. The licensee has failed to ensure that the strategy of hourly monitoring of this resident is implemented when the resident exhibits responsive behaviours.

3. There are not any strategies in place that provide guidance to staff as to when a specific resident is exhibiting responsive behaviours versus taking part in their regular routine. The licensee failed to ensure that strategies have been developed and implemented to respond to the resident's responsive behaviour.

Inspector ID #:	106

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** January 28, 2011