



**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**

**Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch**
**Division de la responsabilisation 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
Sep 27, 29, 30, 2011; Feb 15, 24, 2012	2011_104196_0008	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court, 523 Algoma Street North, THUNDER BAY, ON, P7A-5C2

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

DAWSON COURT
523 NORTH ALGOMA STREET, THUNDER BAY, ON, P7A-5C2

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents, reviewed the residents health care record, reviewed various home policies

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	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).**

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (a) a goal in the plan is met;**
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or**
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits saillants :

1. Progress notes for a resident were reviewed from date of admission in spring of 2011 through to September 6, 2011. The notes identified seven incidents of elopement from the resident's unit and three incidents out of the seven in which this resident was able to exit the home. The care plan that was in place at this time with the focus of "wandering" was reviewed. The residents plan of care was not revised to identify interventions related to the continued wandering until the fall of 2011, even though this resident had eloped from their unit seven times from spring 2011 to September 6, 2011. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective. [LTCHA 2007, c. 8, s. 6 (10).]

2. Inspector reviewed the care plan for a resident and it included behavioural interventions to minimize wandering. Interview was conducted with a staff member and the inspector was told that these behavioural interventions were not accurate and were not followed. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, c. 8, s. 6 (1).]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



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Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

A Critical incident was submitted to the MOHLTC in August 2011 for a resident of the home, outlining an elopement. Inspector reviewed the progress notes from this resident's admission date in the spring of 2011 through to August 2011 and identified three occasions in which the resident had left their unit and staff were unaware. On two occasions, the resident had exited the home. In September 2011, the inspector conducted an interview with a staff member who was familiar with this resident. The staff member's knowledge included information regarding the resident's wandering behaviour. Inspector reviewed the care plan that was in place at the time of these elopement occurrences. The care plan focus of "wandering", included the intervention of "check resident regularly for wandering to ensure resident is safe if it happens". The plan did not identify the frequency of monitoring for this resident.

The licensee failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: 3. Resident monitoring and internal reporting protocols. [O. Reg. 79/10, s. 53 (1).]

Issued on this 24th day of February, 2012

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

Lauren Enhuren #196