



**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
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

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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
Dec 19, 20, 21, 22, 28, 2011; Apr 2, 4, 5, 18, 2012	2011_104196_0016	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, Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Supervisor, Therapeutic Recreationist, Nursing Unit Support Worker (NUSW), 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 records, reviewed the Critical Incident reports submitted to the Ministry of Health and Long-Term Care (MOHLTC), reviewed activity calendar, reviewed various policies and procedures

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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 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 health care record for a resident was reviewed by the inspector on December 21, 2011. This resident had a total of 3 falls in the month of August 2011 as noted on the RAI-MDS "Falls Risk Assessment" online entry dated August 29, 2011.
2. The progress notes dated September 1, 2011 indicate that a bed alarm and a mat on the floor were used as fall prevention strategies.
3. The care plan with an update of September 2, 2011 at 0244hrs did not list a bed alarm or a mat on the floor as measures for fall prevention.

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,S.O.2007,c.8,s.6(1)(c)]

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 that ensures 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following subsections:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The inspector observed on December 22, 2011 from 0900 to 1100hrs, twelve residents sitting at dining room tables on a unit in the home with the TV on with a low volume in the corner of the room. The activity calendar was reviewed and a staff member noted that there was a church service scheduled for this morning off the unit, but stated "no residents went to it". There were no other organized activities scheduled on the calendar for the residents of this unit for the morning of December 22, 2011. The staff member stated "they're bored aren't they". At 1100hrs, of the twelve residents, eight were sleeping in their chairs.
2. Interview conducted with a staff member on December 22, 2011 and they stated that there were no residents on that unit that are Anglican and therefore they didn't approach any residents on the unit to attend.

The licensee failed to ensure that the Recreational and social activities program includes, (c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests. [O.Reg.79/10,s.65(2)(c)]

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 their Recreational and social program includes recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

- s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
 3. A missing or unaccounted for controlled substance.
 4. An injury in respect of which a person is taken to hospital.
 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).
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Findings/Faits saillants :

1. A resident had a fall with injury and was sent to hospital in early September 2011.
2. A Critical Incident report was received by the Ministry of Health and Long-Term Care(MOHLTC) on September 19, 2011.
3. A voice mail message left by the home was retrieved by the duty inspector on September 20, 2011 informing the MOHLTC that a critical incident report was being submitted late.

The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital. [O.Reg.79/10,s.107(3)(4)]

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 that ensures that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management
Specifically failed to comply with the following subsections:**

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Inspector reviewed the "post fall investigation" form dated September 2, 2011 which was completed after a resident's fall with injury. This form identified the resident as a "high risk" for falls prior to this incident and that they had a history of falls. The falls prevention and management program that was in place at the time of this resident's fall with injury on September 2, 2011, did not include reference to the monitoring of residents. An interview was conducted with a Registered staff member on December 21, 2011 and it was stated that there "is no formal way of monitoring residents, just by doing rounds".

The licensee failed to ensure that their falls prevention and management program provides for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. [O.Reg.79/10,s.49(1).]

2. A Critical incident report was submitted to the MOHLTC in September 2011 for an injury from a fall that resulted in transfer to hospital for a resident. Another Critical incident report was submitted to the MOHLTC in October 2011 for an injury from a fall that resulted in transfer to hospital for a resident. An interview was conducted with a Registered staff member on December 22, 2011. They stated that the home uses a tool titled "post fall investigation" for a post-fall assessment. This document was reviewed by the inspector and does not include a clinically appropriate assessment instrument and only outlines the circumstances surrounding a fall. The revised "falls prevention and management" policy, dated November 2011 and the program which includes the use of a "Fall Risk Assessment Tool" was not in effect at the time of these falls and according to the ADOC, "this program for falls prevention will be ready at the end of this month" and "staff members are signed up for training in the fall prevention/management program, upcoming in the new year". A copy of this policy was obtained online through Lotus Notes but the attachments were not available online or in hard copy.

The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [O.Reg.79/10,s.49(2).]

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 that ensures that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls and also ensures that their falls prevention and management program has strategies to reduce or mitigate falls, including the monitoring of residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.**
- 2. Every resident has the right to be protected from abuse.**
- 3. Every resident has the right not to be neglected by the licensee or staff.**
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**
- 5. Every resident has the right to live in a safe and clean environment.**
- 6. Every resident has the right to exercise the rights of a citizen.**
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.**
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.**
- 9. Every resident has the right to have his or her participation in decision-making respected.**
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.**
- 11. Every resident has the right to,**
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,**
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.**
- 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.**
- 13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
- 14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.**
- 15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.**
- 16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.**
- 17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,**
 - i. the Residents' Council,**
 - ii. the Family Council,**
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,**
 - iv. staff members,**
 - v. government officials,**
 - vi. any other person inside or outside the long-term care home.**
- 18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.**
- 19. Every resident has the right to have his or her lifestyle and choices respected.**
- 20. Every resident has the right to participate in the Residents' Council.**
- 21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.**



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22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector observed on 1 North on Dec. 22, 2011 at 0900hrs, a resident sitting in a wheelchair with a brief on and pants pulled up to his knees and a staff member wheeling the chair across the hall to the washroom. The staff member stated to the resident "will get you to stand up in here" as they entered the washroom. The resident's brief and bare legs were exposed to the inspector and anyone else who was in the hallway or looked down the hallway of the unit.

The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [LTCHA 2007,S.O.2007,c.8,s.3(1)1.]

Issued on this 18th day of April, 2012

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

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