



**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

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 28, Dec 8, 9, 2011; Feb 9, 13, 2012	2011_055154_0005	Critical Incident
Licensee/Titulaire de permis		
WEST PARRY SOUND HEALTH CENTRE 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4		
Long-Term Care Home/Foyer de soins de longue durée		
LAKELAND LONG TERM CARE 6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4		
Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs		
GAIL PEPLINSKIE (154)		

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 Care (DOC), Clinical Coordinator, Registered staff, Personal Support Workers (PSW) and some residents.

During the course of the inspection, the inspector(s) conducted the inspection in both the ELDCAP unit (Facility # 2966) and the Long Term Care unit (Facility #2958), conducted a walk-through of 2 resident areas and various common rooms, observed the care of residents, observed staff to resident interactions, reviewed various policies and procedures and some residents' health care records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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. 15. Accommodation services
Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. December 9, 2011 inspector 154 observed, on a resident care unit, scratched, chipped scuffed walls and some with black marks in the family room, den, corridors and in resident rooms. Doors to residents' rooms observed to be heavily scratched.[LTCHA, 2007 S.O. 2007, c.8, s.15.(2) (c)]

2. December 8, 2011 inspector 154 observed, on a resident care unit, scratch marks on lower wall outside dining room and across from nursing station. A resident room has scuffed, scratched lower walls with pieces of plaster missing, another resident room has large chunks of plaster off lower walls with some metal corners exposed and long black scuff marks to lower walls in the corridor. The family room has some areas of walls that are scuffed with long black marks and the walls in two resident rooms have numerous black scuff marks.[LTCHA, 2007 S.O. 2007, c.8, s.15.(2) (c)]

WN #2: 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. (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 :



**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**

1. A resident had a fall on September 25, 2011 and was transferred to hospital for sutures to laceration on forehead. No post falls assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Clinical Coordinator/RN was interviewed and stated that there is no actual tool used for a post falls assessment.

The DOC was interviewed and indicated that the home does not have a post fall assessment tool in place at this time.

The same resident had another fall on December 8, 2011 with haematoma and bruising to face and head and bruising to knee. The resident was not assessed post fall using a clinically appropriate assessment instrument that is specifically designed for falls.

Issued on this 13th day of February, 2012

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

A handwritten signature in cursive script, appearing to read "Geplinski", written in black ink on a white background.