



**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
prévue 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
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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
Aug 22, 23, 24, 27, 28, 2012	2012_031194_0039	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

SEVEN OAKS
9 NEILSON ROAD, SCARBOROUGH, ON, M1E-5E1

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Nurse Manager, Social Worker, Registered Nurse (RN), 2 Registered Practical Nurse (RPN), 2 Personal Care Attendants (PCA), Substitute Decision Maker (SDM) for resident #001 and a family member

During the course of the inspection, the inspector(s) reviewed resident #001's clinical health record and Licensee's policy for Falls Prevention and Management RC-0518-21

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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 O.Reg 79/10, s. 24. 24-hour admission care plan
Specifically failed to comply with the following subsections:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

- 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.**
- 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.**
- 3. The type and level of assistance required relating to activities of daily living.**
- 4. Customary routines and comfort requirements.**
- 5. Drugs and treatments required.**
- 6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.**
- 7. Skin condition, including interventions.**
- 8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).**

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :



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1. The licensee failed to comply with O. Reg s. 24(2)1 when resident #001's plan of care did not identify the risk of falling, and interventions to mitigate the risk

The progress notes for resident # 001 completed by RN, the day of admission, indicate that the SDM identified to nursing staff that resident #001 was at risk for falls. The resident suffered a fall after admission.

RAI MDS Assessment for resident #001 received from CCAC prior to admission indicates that the resident had an unsteady gait.

The Master Profile assessment for resident #001 completed on admission, lists Risk for falls as a behaviour.

The 24 hour plan of care for resident #001 does not identify risk for falls or interventions to mitigate the risk.

2. The licensee failed to comply with O.Reg s.24(4) for resident #001 when the 24 hour admission care plan was not based on the resident's assessed needs, preferences and on the assessments.

SDM states that resident did not require incontinent products at the time of the admission.

The documentation and assessments in the resident's clinical health records at the time of admission, does not support the need for resident #001's use of an incontinent product.

Staff interviewed confirmed incontinent products were applied by staff for resident # 001.

The care set out in the 24 hour admission care plan was not based on resident #001's needs and preferences in regards to the use of incontinent products.

Issued on this 5th day of September, 2012

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

C. Lapierre (194)