



**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
Jul 27, Nov 21, 2011; Jan 31, Feb 22, 23, 2012	2011_051106_0006	Critical Incident

Licensee/Titulaire de permis

Revera Long Term Care Inc.
55 Standish Court, 8th Floor, MISSISSAUGA, ON, L5R-4B2

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

THUNDER BAY INTERIM LONG-TERM CARE CENTRE
445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6

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

MARGOT BURNS-PROUTY (106)

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 Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legende
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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Progress notes for a resident were reviewed on July 28, 2011 by inspector 196. A progress note indicates that, a wanderguard was applied to the resident for safety, related to exit seeking. The resident's plan of care was reviewed on July 28, 2011, by inspector 196, no interventions regarding the use of the wanderguard were found. The licensee failed to ensure that the written plan of care for each resident sets out, clear directions to staff and others who provide direct care to the resident. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (1) (c)] (106)

2. A critical incident report, indicates, a resident became entrapped in their bed rails. The plan of care that was in place for the resident, does not indicate the use of bed rails. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (7)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
- (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
- (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :



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1. A resident became entrapped in their bed rail. The resident was not assessed to use bed rails. The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [O. Reg. 79/10, s. 15 (1) (a)] (106)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. From March 10, 2011 to May 14, 2011, a resident was documented exhibiting responsive behaviours on 6 separate occasions. There were no written strategies found that include techniques or interventions to minimize or respond to the resident's responsive behaviours. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours. [O. Reg. 79/10, s. 53 (4) (b)] (196)

Issued on this 24th day of February, 2012

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