Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2019	2019_671684_0030	015619-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake
3 Kirkland Street West Postal Bag 1757 KIRKLAND LAKE ON P2N 3P4

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

Teck Pioneer Residence
145A Government Road East Postal Bag Service 1757 KIRKLAND LAKE ON P2N 3P4

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

SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 22-23, 2019.

The following intake was inspected during this Critical Incident Inspection:

-One log related to an injury which resulted in significant change in resident condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Restorative Care Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and resident.

The Inspector also conducted daily tours of the resident care ares, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, internal investigation files and resident health care records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Inspector #684 reviewed a Critical Incident (CI) report which was submitted to the Director for an incident that caused an injury to resident #001, for which they were taken to the hospital for and resulted in a significant change to their health status. A review of the CI report showed that resident #001 sustained a significant injury while being transferred and positioned. The resident was sent to hospital for further assessment where by, they were made aware of their treatment options.

Inspector #684 reviewed resident #001's progress notes and noted on a specified day in 2019, there was a progress note which described the incident.

Inspector #684 interviewed Personal Support Worker (PSW) #102 regarding the incident which they were involved in while transferring and positioning resident #001. PSW #102 told the inspector the specifics of the incident.

Inspector #684 interviewed PSW #103 regarding the incident which they were involved in while transferring and positioning resident #001 with PSW #102. PSW #103 described the specifics of the incident involving themselves, PSW #102 and resident #001.

Inspector #684 reviewed the home's policy for transferring and positioning with a review date of May 2019. The procedure stated staff are to "ensure that the resident is well-supported, safe and comfortable."

During an interview held with the Inspector, the DOC indicated a cause why resident #001 was injured while being transferred and positioned by PSW #102 and #103.

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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

According to LTCHA 2007, s.75 subsection (2) states "Every licensee shall ensure that no person performs their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities".

According to O. Reg 79/10, s.219 (1), the times and intervals for the purpose of subsection 76(4) of the Act are annual intervals.

A CI report was submitted to the Director for an incident that caused injury to resident #001. Please see WN #1.

During a review of the CI report, Inspector #684 identified that training related to transferring and positioning was to be provided annually to all PSWs.

During interviews with PSWs #102 and #103, neither could remember receiving transferring and positioning training within the last year.

Inspector #684 reviewed the home's policy and training record for transferring and positioning and was unable to locate where PSW #103 had received their annual training. PSW #102 was documented as having received the training.

Inspector #684 reviewed the home's policy for transferring and positioning, which stated "All newly hired care givers shall be trained during their orientation period. Training comprises of viewing video's supplied by the manufacturer and hands on use with a certified PSW. All PSW's will review the [transferring and positioning training] annually.

In an interview held with the Inspector, the DOC indicated that transferring and positioning training should be completed annually and PSW #103 did not received their annual training. [s. 76. (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 to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations, to be implemented voluntarily.

Issued on this 4th day of September, 2019

[redacted]

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

Original report signed by the inspector.