Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2020	2020_771609_0012	003595-20, 003871-20, 004981-20, 010565-20, 010658-20	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

CHAD CAMPS (609), KEARA CRONIN (759)

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): July 6-10, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

-Three intakes related to resident to resident altercations; and

-One intake related to a fall of a resident.

A Complaint inspection #2020_771609_0011 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Assistant Director of Care/Staff Educator (ADOC), Office Manager, Physician, Nurse Practitioner, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, training logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(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 licensee has failed to ensure clear directions were set out to staff and others who provided direct care to resident #003.

A Critical Incident Systems (CIS) report was submitted to the Director as a result of an incident in which resident #003 sustained a fall with injury on a particular day. The CIS report indicated that resident #003 was provided care by staff without a specific intervention, which resulted in a fall.

Inspector #759 reviewed resident #003's electronic health care records and identified a progress note on a particular day, which described how a staff member found resident #003 on the floor.

A review of resident #003's falls prevention plan of care report found that the RAI Coordinator resolved the specified intervention prior to the resident's fall.

During an interview with the RAI Coordinator, they indicated that they try and make care plans as simple as possible and removed the specified intervention because of the resident's fall risk and transfer status, which made it "pretty evident" the resident required the specified intervention.

During an interview with PSW #104, they indicated that they always provided resident #003 with the specified intervention.

During an interview with PSW #112, they indicated that resident #003 required the specified intervention, but acknowledged at times they would not provide it to the resident.

During an interview with PSW #109, they indicated that they would not have provided resident #003 with the specified intervention.

A review of the home's policy titled "Nursing Care Planning" last reviewed May 2020 indicated that “the plan of care shall give clear directions to staff providing care”.

During an interview with the Administrator/Director of Care (DOC), they verified that the directions were not clear regarding the specified intervention for resident #003. [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 to ensure clear directions are set out to staff and others who provide direct care to 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. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations, at times or at intervals provided for in the regulations.

According to Ontario Regulation (O. Reg.) 79/10, s. 221 (1), for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management training shall be provided to all staff who provide direct care to residents.

According to O. Reg. 79/10, s.221 (2), subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

A CIS report was submitted to the Director related to a fall involving resident #003 that resulted in an injury.

Inspector #759 reviewed the home's policy titled "Falls Prevention and Management Program", which indicated "Ongoing Training for Registered and Direct Care Staff: Review the falls prevention and management program training annually".

a. During an interview with the DOC, the training records for PSW #111 from 2019 for the falls prevention and management program were requested. The DOC was unable to provide training records for PSW #111.

During an interview with PSW #111, they indicated the last time they received the falls retraining was either in 2017 or 2018.

b. A review of the completion record of falls retraining in 2019 for all 42 direct care staff identified that PSW #116 also did not receive falls retraining in 2019.

During an interview with the DOC, they verified that four per cent of their direct care staff did not receive the falls retraining. [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations, at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s Director of Nursing and Personal Care worked regularly in that position on site at the home for at least 35 hours per week.

During the initial entrance conference with the home on July 6, 2020, Inspector #609 was advised by the home’s Assistant Director of Care (ADOC), that they were covering for the Administrator who was off at the time. The ADOC indicated that the Administrator performed the dual role of Administrator and Director of Care.

A review of the Director of Care's signed contract found that they began their dual role of Administrator/Director of Care on in 2012, for a combined total of 35 hours per week.

A review of the home’s Licensing Agreement Approval effective July 1, 2010, found that the home was licensed for 81 beds.

A review of O. Reg. 79/10, found that for a home of its size, the DOC was required to work at least 35 hours per week, while the Administrator was required to work at least 24 hours, for a combined total of at least 59 hours per week.

During an interview with the ADOC, they outlined how they worked three days per week assisting the DOC with “whatever” needed to be done. The ADOC further outlined that they regularly covered for the DOC in their absence.

A review of the ADOC’s signed contract found that they were hired to perform 22.5 hours per week in the role of part time ADOC.

During an interview with the DOC, they verified that their contract as a dual Administrator and Director of Care specified 35 hours per week, but that they actually worked at least 37.5 hours per week. The DOC described how they performed 24 hours per week in the role of Administrator and 13.5 in the role of DOC. The DOC indicated that the ADOC filled the 21.5 hours per week remaining of the DOC hours. [s. 213. (1)]

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 home's Director of Nursing and Personal Care works regularly in that position on site at the home for at least 35 hours per week, to be implemented voluntarily.

Issued on this 30th day of July, 2020

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

Original report signed by the inspector.