Ontario

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 durée

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Dec 04, 2015;	2015_332575_0013 (A2)	011371-15	Resident Quality Inspection

Licensee/Titulaire de permis

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET PARRY SOUND ON P2A 3A4

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

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LINDSAY DYRDA (575) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s). The Director's review was completed on Dec. 3, 2015. Order(s) were rescinded to reflect the Director's review. The Director's order(s) are attached to this report.

Issued on this 4 day of December 2015 (A2)

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

Original report signed by the inspector.

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LINDSAY DYRDA (575) - (A2)

Amended Inspection Summary/Résumé de l’inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 29-July 2 and July 6-10, 2015

During the course of the inspection, an additional eight critical incident logs and a follow-up to four previous compliance orders were inspected.

This inspection addresses both the Lakeland Long-Term Care Home #2958 and ELDCAP #2966.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing & Personal Care (DONPC), Assistant Director of Nursing (ADON), Manager of Support Services, Social Services Manager, Recreation Coordinator, Infection Prevention & Control Resource Person, Quality Management Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Staff, Family Members, and Residents.

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 interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Skin and Wound Care

Sufficient Staffing

Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **14 WN(s)**
- **8 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 76. (2)	CO #001	2015_376594_0005	575
LTCHA, 2007 s. 76. (4)	CO #003	2015_376594_0005	575
LTCHA, 2007 s. 76. (7)	CO #004	2015_376594_0005	575
O.Reg 79/10 s. 8.	CO #002	2015_376594_0005	575

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	Legendé 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. 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #007 set out the planned care for the resident.

Inspector #612 observed resident #007 in a wheelchair with a device in place. On multiple occasions after that, the inspector observed the resident with the device in place, and two other devices applied.

During an interview, resident #007 stated that they are able to apply and remove the device on their own, however staff often apply and remove it for them.

The inspector interviewed S #200 who reported that resident #007 used the device at their (resident) request. S #200 indicated that the resident did not need it for positioning or to remain in their wheelchair. Additionally, S #200 indicated that the other two devices observed were used because the resident had a history of self-transferring.

The inspector reviewed the resident's care plan with S #100 and the ADON who confirmed that the use of the device and the additional two devices was not included in resident #007's care plan, however, it should have been. They also confirmed that the resident used the device for their comfort and the other two devices were used to alert staff if the resident was trying to self-transfer.

Therefore, the resident's written plan of care did not set out the planned care for the resident in regards to the use of all three devices. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the written plan of care for resident #007 set out clear direction to staff and others who provide direct care to the resident.

Inspector #612 reviewed resident #007's care plan. The inspector reviewed the 'toileting' focus of the resident's care plan and noted a certain intervention.

The inspector reviewed the 'bladder' focus of the resident's care plan and noted a different intervention.

The inspector interviewed S #201 and S #202 who confirmed that the intervention under 'toileting' was the correct intervention and that the intervention under the 'bladder' focus was not used. [s. 6. (1) (c)]

3. The licensee has failed to ensure that resident #002's written plan of care set out clear direction to staff and others who provide direct care to the resident.

Inspector #612 reviewed resident #002's health care records. The inspector noted an intervention in the resident's care plan under the 'transferring' focus. Under the 'bed mobility' focus the inspector noted two different interventions.

The inspector interviewed S #202 who indicated that it depended on who was working to determine what intervention was implemented. The inspector interviewed S #200 who indicated that staff are to implement a certain intervention. The inspector reviewed the above interventions with S #100. They confirmed that there was no clear direction for staff in terms of what interventions are to be used for the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that resident #004's written plan of care set out clear directions to staff and others who provide direct care to the resident.

During the course of the inspection, resident #004 advised the inspector of an incident involving S # 203 using an incorrect transfer technique, which caused the resident pain. The resident indicated that typically there is only one staff assisting them during the night.

The inspector reviewed the resident's care plan and noted under the heading 'toileting' it indicated that the resident required extensive assistance of two staff, that at night two staff are required but in the morning they require one staff assistance; however, under the heading 'bladder' it indicated that the resident required one staff to assist to the toilet in the morning and during the night.

During an interview, S # 204 indicated that the amount of staff required fluctuated depending on how the resident was feeling, that typically the resident is independent throughout the day but that at night there was to be two staff members assisting because the resident is weaker. S # 205 also indicated that the resident required two staff assistance at night.

A review of the documentation regarding toileting at night revealed that for a period of one month, on 22/31 occasions the resident was assisted by only one staff for transferring and toileting at night.

The DONPC indicated that the resident did not always require the assistance of two staff, however the care plan should reflect this and it did not. [s. 6. (1) (c)]

5. The licensee failed to ensure that the provision of the care set out in the plan of care for resident #003 was documented.

Resident #003 was observed in a wheelchair throughout the inspection period. The resident's plan of care indicated that the resident was dependent on two staff for all aspects of their care.

The inspector noted that under the Point of Care (POC) flow sheet, directions to staff indicated they were to document the turning and repositioning of the resident on the 'turning and repositioning form'.

The inspector reviewed the turning and repositioning form for a period of one month and noted it was only documented on six occasions when the resident was in bed.

During an interview, S # 206 indicated that staff are required to fill out the form for any

resident who is not able to reposition themselves and that they are supposed to fill out the form for resident #003, however it did not get completed.

The ADON confirmed that the resident's plan of care indicated staff are to complete the form. [s. 6. (9) 1.]

6. The licensee has failed to ensure that resident #001's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Resident #001 was observed on several occasions with a device in place. The ADON confirmed to the inspector that the device was used as a restraint for the resident.

During an interview with the ADON, they indicated that the use of the restraint should be listed under 'safety' in the resident's care plan. The inspector reviewed the resident's most recent care plan and noted the care plan did not identify the use of the device. The ADON confirmed this finding.

During an interview, S # 207 indicated that staff would review the resident's care plan for instructions relating to the type of care to provide to a resident. S #207 confirmed that the device was applied to the resident for safety. S # 208 indicated to the inspector that the resident had the device for approximately two and a half years. [s. 6. (10) (b)]

7. The licensee has failed to ensure resident #003's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Inspector #575 observed resident #003 tilted in their wheelchair. The inspector reviewed the resident's care plan which identified the resident was in a wheelchair at all times on the unit other then in their bed. The care plan did not identify the positioning of the wheelchair.

During an interview, S # 206 indicated that the resident was tilted in their wheelchair for comfort and positioning and that they are repositioned by staff every two hours.

A mobility assessment indicated that the resident was referred for a tilt wheelchair due to concerns related to comfort, safety, positioning, and skin integrity and that the previous device used was too small.

During an interview, the ADON indicated that the resident's care plan did not reflect the use of the tilt wheelchair. [s. 6. (10) (b)]

8. The licensee has failed to ensure that resident #009's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Resident #009's most recent quarterly MDS assessment indicated that the resident had highly impaired vision and did not have visual appliances.

The inspector reviewed the resident's most recent care plan and noted the resident had a history of impaired vision, and that staff were to ensure that the resident's glasses were on and clean when wearing.

The inspector interviewed three staff members: S # 209 indicated that the resident had glasses but that the resident did not like to wear them; S # 101 indicated that they did not think the resident had glasses as they have not seen the resident wear them; S #102 indicated that the resident used to have glasses but that they did not have them anymore.

The ADON confirmed to the inspector that the intervention of ensuring the resident's glasses were on and clean when wearing was an old intervention and the resident no longer had glasses.

The care plan did not reflect the current care needs of the resident. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

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 ensuring that each resident's written plan of care sets out the planned care for the resident and that each resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Resident's Rights-Abuse policy (RSL-RR-007) was complied with.

Inspector #543 reviewed the home's policy titled Resident's Rights-Abuse policy (RSL-RR-007) which stated that if abuse is witnessed, or a resident or family member reports an incident that could be considered abuse that the incident would be reported to the Nurse Manager on duty. The Nurse Manager would then complete the Alleged Nurse Manager Action Form and present that to the Administrator or DONPC.

Inspector #543 spoke with S #100 and the DONPC who confirmed that there was no documentation (aside from the investigation notes completed) regarding an incident of alleged staff to resident abuse. The DONPC stated that regretfully there were no notes regarding the matter, at which time S #100 stated that the Alleged Abuse Nurse Manager Action Form was not completed as indicated in the home's policy. [s. 20. (1)]

2. The licensee has failed to ensure that the home's Resident's Rights-Abuse policy (RSL-RR-007) was complied with.

Inspector #543 reviewed a critical incident report (CI) regarding alleged staff to

resident abuse. According to the CI, S #103 verbally abused a resident. S #103 was overheard speaking to the resident in a loud condescending manner.

Inspector #543 reviewed the home's investigation documents related to this CI which identified that, S #300 witnessed S #103 speak to the resident in a loud, impatient, demeaning and condescending tone.

The inspector spoke with the DONPC who confirmed that S #103 was found to have verbally abused the resident. The DONPC indicated that the Administrator updated the CI confirming that it was determined that verbal abuse had occurred.

Inspector #543 reviewed the home's Resident's Rights-Abuse policy (RSL-RR-007), issue date of October 2011 and last review date of October 2012. The policy defined the meaning of zero tolerance of abuse and neglect as a behaviour of conduct that is detrimental to the resident that would not be tolerated under any circumstance and for any reason. S #103 verbally abused the resident, therefore, the policy was not complied with. [s. 20. (1)]

3. The licensee has failed to ensure that the home's Resident's Rights-Abuse policy (RSL-RR-007) was complied with.

Inspector #543 reviewed a critical incident report (CI) regarding staff to resident abuse. According to the CI, S #105 engaged in a pattern of actions that caused distress to a resident.

Inspector #543 reviewed the home's Resident's Rights-Abuse policy (RSL-RR-007), issue date of October 2011 and last review date of October 2012. The policy defined the meaning of zero tolerance of abuse and neglect as a behaviour of conduct that is detrimental to the resident that will not be tolerated under any circumstance and for any reason. The home concluded that S #105 engaged in a pattern of actions towards the resident that caused distress to the resident, therefore, the policy was not complied with. [s. 20. (1)]

4. The licensee has failed to ensure that the home's Resident's Rights-Abuse policy (RSL-RR-007) was complied with.

Inspector #543 reviewed a critical incident report (CI) regarding alleged staff to resident abuse. According to the CI, S #208 allegedly abused a resident.

Inspector #543 reviewed the home's investigation documentation which described the incident. S #208 refused care to the resident and yelled at the resident.

Inspector #543 reviewed the home's Resident's Rights-Abuse policy (RSL-RR-007), issue date of October 2011 and last review date of October 2012. The policy defined the meaning of zero tolerance of abuse and neglect as a behaviour of conduct that is detrimental to the resident that will not be tolerated under any circumstance and for any reason. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been rescinded:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Inspector #543 reviewed a CI regarding alleged staff to resident abuse. According to the CI, S #208 yelled at a resident which caused distress to the resident.

Inspector #543 reviewed the investigation documentation which described the incident. S #208 refused care to the resident and yelled at the resident.

Inspector #543 spoke with the DONPC regarding the outcome of the investigation related to the incident. The inspector identified that the CI did not indicate the outcome of the investigation completed by the home. The DONPC informed the inspector that they were under the impression that the decision was that there was no disciplinary action for this staff member, that there was no documentation to support that decision, nor were the results of the abuse and/or neglect investigation reported to the Director. [s. 23. (2)]

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 ensuring that when the home makes a report to the Director regarding alleged, suspected or witnessed incident of abuse of a resident by anyone, the report includes the outcome or current status of the individual or individuals who were involved in the incident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm and abuse of a resident by anyone by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #543 reviewed the home's investigation relating to a CI, whereby S #210 allegedly performed improper care which resulted in abuse towards a resident. The result of the investigation was that S #210 did inappropriately conduct themselves in a manner that was considered abuse. This incident was not reported to the Director until seven days later.

The inspector spoke with the DONPC regarding the alleged incident and they indicated that the investigation into the matter started immediately, but that they suspected the home did not report the matter to the Director until the findings of abuse were confirmed. [s. 24. (1)]

2. Inspector #543 reviewed a CI related to alleged staff to resident abuse. S #208 yelled at a resident which caused distress to the resident. This incident was not reported to the Director until two days later. [s. 24. (1)]

3. Inspector #543 reviewed a CI related to alleged staff to resident abuse.

According to the CI, S #105 engaged in a pattern of actions that caused distress to a resident.

According to the DONPC, an allegation of abuse by S #105 towards the resident was brought forward by S #110 to the ADON. The ADON did not report the incident to the Director, or document any findings and no investigation into the allegation was initiated. According to the DONPC, the ADON thought it was a momentary lapse in judgment on S #105's part and would not be repeated.

Then, approximately one and a half months later, S #106 completed an Alleged Abuse Reporting Form stating that they overheard S #105 causing distress to the resident. When the DONPC received the information the DONCP realized that S #105's behaviour was a more significant concern than the ADON had thought when the previous allegation was brought forward. The DONPC initiated an investigation into the allegation of abuse. It was not until six days later, that the allegations of abuse were reported to the Director. [s. 24. (1)]

4. During the inspection period, resident #004 advised Inspector #575 that S #203 had roughly and improperly assisted them out of bed during the night. The resident indicated that they were scared at the time, and that they experienced pain due to improper care.

The inspector notified the DONPC of the incident and the DONPC initiated an investigation immediately, however the incident was not reported to the Director until two days later. [s. 24. (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 ensuring that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for personal care staffing that addressed situations when staff cannot come to work.

Inspector #612 was provided a copy of the home's policy titled Staffing Back-Up Plan - Index O.P. 23, effective June 2012, review date of July 2013. During an interview, the DONPC indicated that the home does not have a back-up plan for personal care staff and that they would just call extra staff in as needed. The DONPC confirmed that the home's written staffing back-up plan was related to registered staff only and not to personal care staff. [s. 31. (3)]

2. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Inspector #612 requested the written record of the annual evaluation of the staffing plan. The DONPC indicated that the home reviews the staffing plan annually, however there was no written record kept by the home. [s. 31. (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 ensuring that the staffing plan includes a back-up plan for personal care staffing that addresses situations when staff cannot come to work and that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002, exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #612 reviewed resident #002's health care record and noted that the resident had impaired skin integrity. The inspector reviewed the resident's electronic wound care record under the wound tracker section and noted that on several occasions the resident did not receive weekly wound assessments completed by a member of the registered staff.

Inspector #612 interviewed S #107 who confirmed that the wound assessments are to be completed at a minimum, weekly and documented electronically in the wound tracker section.

Inspector #612 interviewed the ADON who confirmed that the wound assessment reports are to be completed at least weekly and documented electronically in the wound tracker section. [s. 50. (2) (b) (iv)]

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 ensuring that residents exhibiting altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff released resident #001 from the physical device and repositioned them at least once every two hours.

Resident #001 was observed on several occasions with a device in place. The ADON confirmed to the inspector that the device was used as a restraint for the resident.

During the inspection, the inspector observed the resident for a period of two hours. The resident was observed in their room, with the restraint applied. The restraint documentation was reviewed and the inspector noted that according to the restraint documentation, the resident was last repositioned approximately two hours before the inspector began observing.

Approximately 40 minutes into the observation, S #212 entered the resident's room, put away the resident's laundry, and left the room. No repositioning was observed.

Approximately one hour later, S #212 assisted the resident to the dining room for supper. The resident's restraint was not released and the resident was not repositioned. The resident then remained in the dining area.

The inspector reviewed the restraint documentation and noted there was no documentation regarding positioning, removal of the restraint or the resident's response to the restraint for approximately seven hours.

The next day, the inspector observed the resident for approximately two and a half hours. During this time, the resident's restraint was not released.

The inspector reviewed the hourly restraint documentation for one month and noted the documentation was incomplete on several occasions and on eight occasions, the resident was not repositioned every two hours as required, instead was repositioned every three hours. [s. 110. (2) 4.]

2. The licensee has failed to ensure that resident #001's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #001 was observed on several occasions with a device applied. The ADON confirmed to the inspector that the device was used as a restraint for the resident. The ADON and S #108 indicated that the restraint reassessment is documented in the progress notes (e-notes) every eight hours by the Registered staff.

The inspector reviewed the progress notes for a period of one month and noted the eight hour reassessments were not completed as required. On 30 occasions, the

reassessments were not completed every eight hours as required. [s. 110. (2) 6.]

3. The licensee has failed to ensure that the documentation included the person who applied the device and the time of application.

Resident #001 was observed on several occasions with a device applied. The ADON confirmed to the inspector that the device was used as a restraint for the resident.

The inspector reviewed the restraint record for a period of one month for resident #001. The inspector noted the documentation did not include the application of the device on seven occasions.

The inspector interviewed S #205 who indicated that staff are to complete the paper restraint record every hour including when applied. [s. 110. (7) 5.]

4. The licensee has failed to ensure that the documentation included the removal of the device, including time of removal or discontinuance and the post-restraining care.

Resident #001 was observed on several occasions with a device applied. The ADON confirmed to the inspector that the device was used as a restraint for the resident.

The inspector reviewed the restraint record for a period of one month for resident #001. The inspector noted the documentation did not include the removal of the device on four occasions.

The inspector interviewed S #205 who indicated that staff are to complete the paper restraint record every hour including when removed. [s. 110. (7) 8.]

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 ensuring that when residents are restrained, staff release the resident from the physical device and reposition at least once every two hours, staff reassess the effectiveness of the restraining at least every eight hours, the documentation includes the person who applied the device and the time of application, and the documentation includes the removal of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, that was exclusively for drugs and drug-related supplies and that was secure and locked.

During an interview, S #106 indicated that the physician medication review was the most current medication orders for residents.

Inspector #543 conducted a random audit of resident rooms and identified that the following three residents had drugs either at their bedside or in their bathroom:

Resident #016: four separate drugs were observed in the resident's room and/or at the resident's bedside. The inspector reviewed the resident's most recent medication review and identified that there was no physician's orders for some of the medications, or a physician's order identifying that the resident was able to self-medicate or keep the drugs in their room.

Resident #018: two separate drugs were observed in the resident's bathroom. The inspector reviewed the resident's most recent medication review and identified that there was no physician's order identifying that the resident was able to self-medicate or keep the drugs in their room.

Resident #017: two separate drugs were observed at the resident's bedside. The inspector reviewed the resident's most recent medication review and identified that there was no physician's order identifying that the resident was able to self-medicate or keep these drugs in their room and there was no order for either drug in the resident's health care record.

The inspector spoke with S #109 who indicated that typically there are no drugs left at any resident's bedside and if a resident was to have a drug at their bedside or they were able to self-medicate, a physician's order was required.

Inspector #543 spoke with the DONPC regarding the home's protocol on residents self medicating and/or drugs being left at the bedside or in the residents' rooms. The DONPC stated that no drugs were to be left at the bedside and if there was a circumstance where a resident needed to self medicate, that the drug could be left at the bedside, however it was a requirement to have a physician's order. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

Inspector #543 observed a medication room on a home area where there was a controlled substance stored in the refrigerator, which was not locked.

The inspector spoke with S #109 who stated that all controlled substances are locked in separate locked areas in the medication carts (that lock) and that the medication cart is kept in the locked medication room when not in use.

Therefore, a controlled substance was stored in a refrigerator in the medication room, which was not double locked. [s. 129. (1) (b)]

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 ensuring that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that is secure and locked, and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

During the Resident Quality Inspection in 2014, a Compliance Order (CO)#001 was issued stating that the licensee was to ensure that the home's Mantoux Skin Testing Policy was complied with by September 30, 2014.

During a follow up inspection #2015_376594_005, the ADON stated that the home's

Mantoux Skin testing policy had been replaced with the Tuberculin Skin Testing (TST) policy #IPC-SUR-010. As a result of the inspection, the order was re-issued stating that the licensee was to ensure that the home's TST policy was complied with and implemented in accordance with all applicable requirements under the Act by July 3, 2015.

Inspector #575 reviewed the TST policy #IPC-SUR-010 last revised June 2015. The policy indicated that:

b) All residents 65 years of age and older admitted to Lakeland LTC will:
i) have a chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility. If the x-ray was not done within the 90 days prior to admission, it should be taken within 14 days of admission. A copy of the x-ray report must be provided to Lakeland LTC and be placed on the resident's chart.
c) All residents less than 64 years of age and younger admitted to Lakeland LTC who are previously skin test negative or unknown , will complete part "b" above and complete a 2-step TST initiated within 14 days of admission, unless contraindicated.
Note: if resident is previously documented 2-step TST only a one step is necessary.

The inspector reviewed the health care records of three residents. One resident had a one-step Mantoux completed and the ADON reported to the inspector that the second step was being initiated. The inspector noted that the resident did not have a chest x-ray completed. The ADON indicated that the policy was not correct and that residents who are under 65 years of age do not need a chest x-ray and only need the two-step skin test.

The inspector reviewed the guidelines located on the North Bay Parry Sound District Health Unit website and noted that the policy outlined the recommendations provided by the health unit, whereby residents under 65 years of age do require a chest x-ray and a two-step tuberculin skin test.

During an interview, the DONPC and ADON confirmed that the resident did not have a chest x-ray completed and that the second step of the skin test was completed outside of the 14 day period after admission. [s. 229. (10) 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 ensuring that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included the consent by the resident or if the resident is incapable, by the substitute decision maker (SDM).

Resident #001 was observed on several occasions with a device applied. The ADON confirmed to the inspector that the device was used as a restraint for the resident.

The inspector reviewed the resident's plan of care and noted a consent signed by the resident's SDM for a different device for increased safety. The consent for device observed was not located in the resident's health care record, and the ADON confirmed they were not able to find the consent. The device was not consented to by the SDM. [s. 31. (2) 5.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids labelled within 48hrs of admission and of acquiring, in the case of new items.

Inspector #612 conducted a tour of the home. The inspector observed multiple bottles of shaving cream, body wash, shampoo and lotion as well as nail clippers and brushes, which were used and unlabelled in both the shower and tub rooms on all home areas.

Inspector #612 confirmed with the DONPC that residents' personal items are to be labelled. [s. 37. (1) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview, the S #301 indicated to Inspector #575 that the Residents' Council currently does not participate in developing the satisfaction survey.

S #302 confirmed that the satisfaction survey was not previously reviewed by the Residents' Council, however indicated that it would be reviewed with the Residents' Council working group at their next meeting. [s. 85. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence.

Inspector #612 reviewed a CI which was submitted. A resident reportedly fell, was sent to hospital, and returned to the home on the same day with a diagnosis of a fracture.

Inspector #612 reviewed the resident's flow sheets. Prior to the fall, the resident was independent with care, requiring supervision or set up help with tasks such as dressing, personal hygiene and toileting. After the fall, the resident required extensive assistance to total dependence from one to two staff for tasks such as dressing, personal hygiene and toileting.

Inspector #612 interviewed the DONPC who confirmed that the CI report was filed late, four days after the incident. [s. 107. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy titled 'Minimizing Restraining of Residents: Use of Restraint,s RSL-SAF-035' last reviewed January 2015 addressed the types of physical devices permitted to be used.

Inspector #575 reviewed the home's policy titled 'Minimizing Restraining of Residents: Use of Restraints, RSL-SAF-035' last reviewed January 2015. The inspector noted that the policy indicated on page 1/21 that types of physical devices permitted to be used would be addressed. On page 6/21, the policy stated that only legally approved physical devices would be used and on page 7/21 prohibited devices NOT to be used were listed. The policy did not address the types of physical devices permitted to be used.

During an interview, the ADON indicated that staff are told of the physical devices permitted to be used during training. The ADON confirmed that the physical devices permitted to be used were not in the policy. [s. 109. (d)]

Issued on this 4 day of December 2015 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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 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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LINDSAY DYRDA (575) - (A2)

Inspection No. / No de l'inspection : 2015_332575_0013 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011371-15 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 04, 2015;(A2)

Licensee / Titulaire de permis : LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

LTC Home / Foyer de SLD : LAKELAND LONG TERM CARE SERVICES CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LEN FABIANO

To LAKELAND LONG TERM CARE SERVICES CORPORATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A1)
The licensee shall ensure that the written plan of care for resident #002, #007, #004 sets out clear directions to staff and others who provide direct care to the resident.

Specifically, resident #002 s plan of care shall provide clear directions related to what type of product can be left between the resident and the therapeutic surface;

Resident #007 s plan of care shall provide clear directions related to toileting outlining the type of equipment, assistance, and frequency required by the resident and the resident s level of continence; and

Resident #004 s plan of care shall provide clear directions related to toileting and transferring outlining the type of assistance the resident requires and the time of day the assistance is needed. The plan of care shall also outline the resident s preferred technique to assist them with transferring, provided it is safe.

The licensee shall ensure that all staff who provide direct care to resident #002, #007, and #004 are aware of any changes made to these residents plans of care.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004's written plan of care set out clear directions to staff and others who provide direct care to the resident.

During the course of the inspection, resident #004 advised the inspector of an incident involving S # 203 using an incorrect transfer technique, which caused the resident pain. The resident indicated that typically there is only one staff assisting them during the night.

The inspector reviewed the resident's care plan and noted under the heading 'toileting' it indicated that the resident required extensive assistance of two staff, that at night two staff are required but in the morning they require one staff assistance; however, under the heading 'bladder' it indicated that the resident required one staff to assist to the toilet in the morning and during the night.

During an interview, S # 204 indicated that the amount of staff required fluctuated depending on how the resident was feeling, that typically the resident is independent throughout the day but that at night there was to be two staff members assisting because the resident is weaker. S # 205 also indicated that the resident required two staff assistance at night.

A review of the documentation regarding toileting at night revealed that for a period of one month, on 22/31 occasions the resident was assisted by only one staff for transferring and toileting at night.

The DONPC indicated that the resident did not always require the assistance of two staff, however the care plan should reflect this and it did not. (575)

2. The licensee has failed to ensure that resident #002's written plan of care set out clear direction to staff and others who provide direct care to the resident.

Inspector #612 reviewed resident #002's health care records. The inspector noted an intervention in the resident's care plan under the 'transferring' focus. Under the 'bed mobility' focus the inspector noted two different interventions.

The inspector interviewed S #202 who indicated that it depended on who was working to determine what intervention was implemented. The inspector interviewed S #200 who indicated that staff are to implement a certain intervention. The inspector reviewed the above interventions with S #100. They confirmed that there was no clear direction for staff in terms of what interventions are to be used for the resident. (612)

3. The licensee has failed to ensure that the written plan of care for resident #007 set out clear direction to staff and others who provide direct care to the resident.

Inspector #612 reviewed resident #007's care plan. The inspector reviewed the 'toileting' focus of the resident's care plan and noted a certain intervention.

The inspector reviewed the 'bladder' focus of the resident's care plan and noted a different intervention.

The inspector interviewed S #201 and S #202 who confirmed that the intervention under 'toileting' was the correct intervention and that the intervention under the 'bladder' focus was not used. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 11, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A2)
The following Order has been rescinded:

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4 day of December 2015 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDSAY DYRDA - (A2)

Service Area Office /
Bureau régional de services : Sudbury

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

AMENDED JANUARY 5, 2016.

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public
Name of Director:	**Mary Nestor**
Order Type:	**□ Amend or Impose Conditions on Licence Order, section 104** **□ Renovation of Municipal Home Order, section 135** **X Compliance Order, section 153** **□ Work and Activity Order, section 154** **□ Return of Funding Order, section 155** **□ Mandatory Management Order, section 156** **□ Revocation of Licence Order, section 157** **□ Interim Manager Order, section 157**
Intake Log # of original inspection (if applicable):	**011371-15**
Original Inspection #:	**2015_332575_0013**
Licensee:	**Lakeland Long Term Care Services Corp.**
LTC Home:	**Lakeland Long Term Care Services**
Name of Administrator:	**Len Fabiano**

Background:

Ministry of Health and Long-Term Care (MOHLTC) Inspectors # 543, #575 and #612 conducted an inspection of **Lakeland Long Term Care Services Corporation** (**Lakeland** or the **Home**), in Parry Sound, ON, on June 29 to July 2, and July 6 to 10, 2015 (2015_332575_0013 (A1)). The inspection was a Resident Quality Inspection. During the inspection the Inspectors found that the Licensee, **Lakeland Long Term Care Services Corporation** (the **Licensee**), failed to comply with certain provisions of the *Long-Term Care Homes Act, 2007* (LTCHA). Pursuant to s.153 (1)(a) of the LTCHA, inspectors #575 and #612 issued two orders:

Compliance Order #001 (order), in relation to LTCHA, s. 6 (1) states:

> The Licensee shall ensure that the written plan of care for resident #002, #007, #004 sets out clear directions to staff and others who provide direct care to the resident.

Specifically, resident #002's plan of care shall provide clear directions related to what type of product can be left between the resident and the therapeutic surface;

Resident #007's plan of care shall provide clear directions relating to toileting outlining the type of equipment, assistance, and frequency required by the resident and the resident's level of continence; and

Resident #004's plan of care shall provide clear direction related to toileting and transferring outlining the type of assistance the resident requires and the time of day the assistance is needed. The plan of care shall also outline the resident's preferred technique to assist them with transferring provide it is safe.

The licensee shall ensure that all staff who provide direct care to resident #002, #007, and #004 are aware of any changes made to these residents' plans of care.

The Order must be complied with by the Licensee by: December 11, 2015 (A1).

Compliance Order #002 relates to LTCHA, s. 20(1) states:

The licensee shall ensure that the home's written policy to promote zero tolerance of abuse and neglect (Resident's Rights –Abuse policy RSL-RR-007) of residents is complied with.

Specifically, the licensee shall:

Conduct an in-service to re-educate all staff on the home's policy to promote zero tolerance of abuse and neglect of residents including reporting requirements, the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations;

Conduct an in-service to re-educate all direct care staff on abuse recognition and prevention and mental health issues (including caring for persons with dementia).
Evaluate the education by observing and communicating with staff to identify further learning needs if required.

The Order must be complied with by the Licensee by: Nov. 30, 2015 (A1).

The Licensee has made a timely request that the Director review Orders #001 and #002.

Compliance Order #001: The Inspector's Order has been confirmed.

Compliance Order #002: The Inspector's Order has been rescinded.

A Director's Order is being issued.

Order:	#001

To **Lakeland Long Term Care Services Corp.** you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:

LTCHA, 2007 Section 20(2)

Policy to promote zero tolerance

20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Contents

(2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;

(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) shall set out the consequences for those who abuse or neglect residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Communication of policy

(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

LTCHA, 2007, O Regulation 96

Policy to promote zero tolerance

96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused

or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order:

The Licensee shall do the following for achieving compliance with LTCHA, s. 20 (2) and the Regulation, section 96:

1. Undertake a comprehensive review of the Home's policies to promote zero tolerance of abuse and neglect of residents, and make revisions where required, in order to ensure compliance with all elements of the legislative and regulatory requirements.
2. This review and revision shall also include the following, at a minimum:
   a. clearly set out what constitutes abuse and neglect by ensuring definitions of abuse are aligned with legislative definitions;
   b. provide clear direction on timelines for mandatory reporting;
   c. a description of the Home's process to ensure that "a person" (i.e. anyone) who has reasonable grounds to suspect any of the mandatory reporting elements have occurred must report the matter to the Director (under the LTCHA);
   d. provide for a program, that complies with the regulations, for preventing resident abuse and neglect;
   e. contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
   f. identifies measures and strategies to prevent abuse and neglect; and
   g. an accurate reference to the current legislation. i.e. the *Long-Term Care Homes Act, 2007* and Regulation 79/10.
3. Ensure that all staff are provided with education and training on the revised policy.

Grounds:

Licensee's Policies and Procedures

During the course of conducting this Review, I read and considered the Licensee's policies and procedures specific to the promotion of zero tolerance of abuse and neglect, internal and external reporting and mandatory reports gathered by the inspectors during their inspection:

- Abuse Policy [RSL-RR-007]
- Confidence to Report [RSL-RR-008]
- Alleged Abuse Reporting Form, and
- Alleged Abuse – Nurse Manager Action Form (collectively referred to as "the policies").

Section 20(2) of the LTCHA and section 96 of the Regulation, list the required elements that must be in place, at a minimum, in a Licensee's policy to promote zero tolerance of abuse and neglect. I reviewed the Licensee's policies against the requirements of section 20(2) of the LTCHA and section 96 of the Regulation. The Licensee's policies meet some but not all of the required elements. The policies do not include the elements required by sections 20(2)(c) and (d) of the LTCHA and section 96(a), (b) and (c) of the Regulation:

20(2)(c)	provide for a program, that complies with the regulations, for preventing abuse and neglect;
20(2)(d)	an explanation of the duty under section 24 of the LTCHA to make mandatory reports;
96(a)	procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
96(b)	procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; and
96(c)	identifies measures and strategies to prevent abuse and neglect.

- For example – section 20(2)(d) of the LTCHA, specifically, mandates that the Licensee's policy contains an explanation of the duty under s. 24 to make mandatory reports. The Licensee's Abuse Policy does not explain the duty to make mandatory reports under s. 24 because it fails to explain:
  - that "a person," which includes a staff member, has a duty to report under s. 24, irrespective of the Licensee's duty;
  - that staff members must report any incident or suspected incident of resident abuse or neglect to the Director under the Act;
  - that a person, including a staff member, must report a suspicion of abuse or neglect of a resident that results in harm or a risk of harm to the resident, including the information upon which the suspicion is based, where the person has reasonable grounds for the suspicion; and
  - that the duty to report to the Director (under the Act) is immediate.

The policies are confusing and ambiguous about timing, process, responsibilities, and obligations for reporting when reasonable grounds to suspect abuse, neglect or any of the other situations listed in LTCHA s.24(1) arise.

- For example – the section entitled "What to do if abuse is witnessed" starting on page 6 of the Abuse Policy [RSL-RR-007] reads as follows:

  "*A person who has reasonable rounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information:*..." and immediately lists four of the five elements of the mandatory reports, as well as an internal reporting hierarchy of the Home's management team – omitting the critical element for the requirement to report "to the Director" – i.e. the Director under the LTCHA.

The policies do not provide a clear and accurate explanation to front-line and management staff, or anyone, on their individual obligations for reporting to the Director immediately, under s. 24(1) of the LTCHA, irrespective of the Licensee's duty to report.

- For example – during an interview with the Inspector #543 on July 7, 2015, the Director of Nursing indicated the Home had immediately started an investigation into an allegation of abuse of a resident by a staff member, but the allegation or suspicion was not reported to the ministry until it was confirmed that the actions of the staff were considered abuse through the findings of the Home's investigation.

The policies do not contain a comprehensive description of procedures and interventions on how to deal with any person (not only staff), who have abused or neglected or allegedly abused or neglected residents. The Home's policy addresses the staff component of that requirement, but not other persons (such as visitors, family members, or others) as required by O Reg 96(b).

The policies do not contain a description of a program to prevention abuse and neglect of residents, as required by LTCHA s. 20(2)(c), and O Reg 96(c).

The policies contain descriptions of interventions and approaches to support and assist staff who have been suspected of abusing a resident, as well as support to staff when they have difficulty coping with resident-care related situations (for example – "Available Assistance" section of Policy RSI-RR-007), but there is nothing addressing procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, as required by O Reg 96(a).

The policies and procedures require a comprehensive review and revision by the Licensee in order to ensure compliance with all elements of the legislative and regulatory requirements and clear direction to the Licensee's staff. As part of this review and revision, the Licensee should also ensure that definitions of abuse in its policies are more consistent with legislative definitions, as well as an accurate reference to the current legislation, i.e. the *Long-Term Care Homes Act, 2007* and Regulation 79/10 (not the *Nursing Homes Act*, which was repealed when the LTCHA came into effect on July 1, 2010).

This order must be complied with by:	Parts 1. and 2. of the order must be complied with by: December 18, 2015. Part 3. of the order must be complied with by: ~~January 15, 2016.~~ January 29, 2016.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 3rd day of December, 2015.	
Signature of Director:	
Name of Director:	Mary Nestor