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
Jun 18, 2021	2021_853692_0013	007496-21	Critical Incident System

Licensee/Titulaire de permis

West Parry Sound Health Centre
6 Albert Street Parry Sound ON P2A 3A4

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

Lakeland Long Term Care (Eldcap)
6 Albert Street Parry Sound ON P2A 3A4

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

SHANNON RUSSELL (692)

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): June 7-11, 2021.

The following intake was inspected upon during this Critical Incident System inspection:

-One log, which was related to a critical incident that the home submitted to the Director related to Improper/incompetent treatment of a resident that resulted in harm or a risk of harm to the resident.

A Follow Up inspection #2021_853692_0011 and a Critical Incident System inspection #2021_853692_0012 for Lakeland Long Term Care were conducted concurrently with this inspection.

Inspector Jennifer Nicholls #691 was present throughout this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Associate Director of Nursing (ADON), Nurse Managers (NMs), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), 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 and resident to resident interactions, observed infection control practices, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

A Personal Support Worker (PSW) informed a Registered Practical Nurse (RPN), that while they were in the process of assisting a resident during a specific activity of daily living (ADL), the resident lost their balance, and the PSW had guided the resident to the floor. The RPN reviewed the resident’s care plan at the time of incident, which indicated that the resident required assistance of two staff for the specific ADL, with the use of a specific assistive aid.

In an interview with the RPN, they indicated that the PSW had assisted the resident with a specific ADL alone, at which time they lost their balance falling to the floor.

During an interview with the Director of Nursing (DON), they indicated that staff were to follow the care plan for all residents. They identified that the PSW had not safely assisted the resident, as they required the assistance of two staff and the PSW had assisted them by themselves; which had placed the resident at risk for injury.

Sources: Critical Incident System (CIS) report; internal investigation notes; a resident's care plan, assessments and progress notes; licensee policy titled, "Lift Transfers Resident Centred Safe Lift Program"; and, interviews with a RPN, DON, and other staff. [s. 36.]

Issued on this 29th day of June, 2021

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

Original report signed by the inspector.