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

Sudbury Service Area Office
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Original Public Report

Report Issue Date July 7, 2022
Inspection Number 2022_1449_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
West Parry Sound Health Centre

Long-Term Care Home and City
Lakeland Long Term Care (Eldcap), Parry Sound

Lead Inspector
Amanda Belanger (736)

Inspector Digital Signature
Amanda Lee Claire Belanger
Digitally signed by Amanda Lee Claire Belanger
Date: 2022.07.12 13:48:30 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-13, 2022.

The following intake(s) were inspected:

- One log related to medications not being administered as prescribed, and,
- one log related to an allegation of improper care of a resident.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102 (1) (b)

The licensee has failed to ensure that hand hygiene was provided to the residents prior to meal service.

During an observation of meal service, it was noted that residents were not offered nor assisted with hand hygiene prior to the start of the meal service.

After discussion with the Infection Prevention and Control (IPAC) lead in the home, on additional observations in the dining room, the Inspector noted staff offering alcohol based hand rub (ABHR) to residents prior to the start of the meal service.

Date Remedy Implemented: May 11, 2022. [736]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with s. 6 (7) under the Long-Term Care Homes Act, 2007 and s. 6 (7) under FLTCA

The licensee has failed to ensure that care was provided to a resident as per their plan of care.

Rationale and Summary
a) The resident had a physician's order that directed staff to provide a treatment at specific time intervals.

The resident's electronic treatment administration record (eTAR) indicated the treatment was not provided at the specific time interval identified in the physician's order.

The Director of Nursing (DON) indicated that the physician's orders were part of the resident's plan of care, and that care was to be provided as set out in the physician orders. The DON indicated that was not provided as per the plan of care.

Sources: The resident's physician orders, progress notes, and eTAR; and, interviews with the physician, DON and other relevant staff. [736]

b) The physician gave an order to provide specific care to the resident. The care was not provided for three days.

The DON indicated that the physician's orders were part of the resident's plan of care, and with the care not being completed as per the doctor's order, care was not provided to the resident as set out in the plan of care.

Sources: The resident's progress notes and physician orders; interview with the DON and other relevant staff. [736]

WRITTEN NOTIFICATION: REPORTS TO THE DIRECTOR

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 107 (4) 2 ii.

The licensee has failed to ensure that the resident's name was included in a report to the Director related to an allegation of improper care of the resident.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director for an allegation of improper care. The report did not include the name of the resident involved.

Sources: The CI; and interviews with the Associate Director of Nursing (ADON) and DON. [736]

WRITTEN NOTIFICATION: MEDICATION ADMINISTRATION

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 131 (2)

The licensee has failed to ensure that the resident's medication was administered as per the prescriber's directions.

Rationale and Summary
The resident had an as needed (PRN) medication ordered, with the clinical reasons for which the medication could be administered.

During a two month time period, it was noted that the medication was given to the resident, although the clinical reasons for administration were not met.

The physician indicated that if the resident was being administered the PRN medication without clinical reasons being met, the medication was not being administered as per the prescriber's directions.

Sources: The CI report; internal investigation notes; the resident's progress notes, eMAR, and physician's orders; interviews with RPNs, the physician, and other relevant staff. [736]

WRITTEN NOTIFICATION: DOCUMENTATION OF MEDICATION ERRORS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 135 (1) a

The licensee has failed to ensure that when there was a medication error that involved the resident, that the error was documented.

Rationale and Summary
There were two medication errors that involved a resident.

There was no record kept of the medication errors.

The Assistant Director of Nursing (ADON) and DON confirmed that a medication error was noted, however, there was no record kept of the error and there should have been.

Sources: The resident's progress notes and eMAR; Medisystem policies and procedures; medication error binder; interviews with the ADON, DON and other relevant staff. [736]

WRITTEN NOTIFICATION: REPORTING TO THE DIRECTOR

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee has failed to ensure that anyone who had reasonable grounds to suspect neglect by a staff member that resulted in a risk of harm to the resident, immediately reported the suspicion to the Director.

Rationale and Summary
Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subjection 24. (1).

The Director was notified of an incident of potential resident neglect, the day after it took place.

The ADON indicated that staff should have brought forward the concern regarding potential neglect immediately, so that it could have been reported to the Director.

Sources: The CI; internal investigation notes; licensee policy titled ADM-RF Abuse-Investigation, last revised July 2016; and, interview with ADON, and other relevant staff. [736]

WRITTEN NOTIFICATION SDM NOTIFICATION OF ABUSE

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 97 (1) b

The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was made aware of an allegation of neglect.

Rationale and Summary
The RPN brought forward an allegation of neglect towards the resident.

The ADON indicated that the SDM was not notified.

Sources: The CI; internal investigation notes; resident's progress notes; licensee policy titled ADM-RF Abuse Investigation, last revised July 2019; and, interview with ADON. [736]