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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2020	2020_683126_0021	017408-20	Complaint

Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Lancaster Long Term Care Residence
105 Military Road North P.O. Box 429 Lancaster ON K0C 1N0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 21 and November 9, 2020 (onsite). October 22, 23, 26, 27, 28, 29, 30, Nov 3, 4, 5, 6, 10, 2020 (off site)

Log #017408-20 complaint inspection related to concerns with several care areas (fall, nutritional care, medications...)

During the course of the inspection, the inspector(s) spoke with Administrator/Director Of Care (ADM/DOC), the Nursing Consultant of Responsive Health Management, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Physiotherapist, the RAI Cordinnator, the family member and the resident.

During the course of the inspection, the inspector reviewed the resident health care record and observed provision of resident care and service.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that clear direction was provided to staff related to the application of the seat belt.

On a specific date in 2020, resident #001 was observed sitting in wheelchair(w/c) with a front closure seat belt. The resident was unable to undo the seat belt when requested by Inspector #126 and RPN #101. The belt was undone at that time.

Resident #001's health care record was reviewed. The seat belt was originally applied as a Personal Assistance Services Devices (PASD) because the resident was able to undo at that time. On specific date in 2020, resident #001 had a fall with the w/c with the seat belt on. No serious injury was noted. The resident progress notes were reviewed and several notes after that date, indicated that resident had several falls or slipped out of the w/c without the seat belt on.

The Administrator/ Director of Care (ADM/DOC) #100, several Registered Nurses (RNs) and Registered Practical Nurses (RPNs) indicated that usually resident #001 could on command or when they wanted, undo the seat belt. Some Registered Nursing staff indicated that the resident would not have the seat belt on during their shift because it was safer for the resident.

Sources: resident #001's progress notes and care plan; interviews with ADM/DOC #100 and several registered nursing staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure resident #001 fall are communicated to the Substitute Decision Maker (SDM).

Resident #001 fell several times since their admission to the home. In the progress notes, it was documented, mostly on the evening or night shift, that the SDM would be notified the next day. In a few instances, there is no follow up progress notes indicating that the SDM was notified.

Discussion with ADM/DOC #100 who indicated that it is possible that the SDM was not notified of all the falls. The ADM/DOC also indicated that there is not a clear follow up process for staff to ensure that the SDM was notified of all the falls.

Sources: resident #001 's progress notes and ADM/DOC call log with the SDM and family; interview with ADM/DOC #100 and other staff [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure clear directions related to the front closure seat belt and notification of the SDM, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (3) A licensee is exempt from the requirement under clause (1) (a) to hold a care conference within six weeks of admission with respect to a resident,
(a) who is being relocated to another long-term care home operated by the same licensee and section 208 of this Regulation applies; or O. Reg. 79/10, s. 27 (3).
(b) who is transferring to a related temporary long-term care home, a re-opened long-term care home or a replacement long-term care home operated by the same licensee. O. Reg. 79/10, s. 27 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care conference within six weeks of admission was held .

Resident #001 was admitted to the home on a specific date in 2020 and as per the resident's health care record, the care conference was held approximately 6 months later.

The ADM/DOC #100 could not explain why the admission care conference was held several months post admission.

Sources: Resident #001'health care record, more specifically the progress notes; and interviews with the ADM/DOC #100 and other staff. [s. 27. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 137. Restraining by administration of drug, etc., under common law duty

Specifically failed to comply with the following:

s. 137. (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. Circumstances precipitating the administration of the drug. O. Reg. 79/10, s. 137 (2).
2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug. O. Reg. 79/10, s. 137 (2).
3. The resident's response to the drug. O. Reg. 79/10, s. 137 (2).
4. All assessments, reassessments and monitoring of the resident. O. Reg. 79/10, s. 137 (2).
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug. O. Reg. 79/10, s. 137 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a discussion with the Substitute Decision Maker (SDM) following the administration of drug to resident #001, was explained and the reasons for the use of the drug.

Resident #001 health care record was reviewed, and it was noted that on a specific date in 2020, the resident exhibited responsive behaviors. RPN #105 contacted Physician #111 who prescribed a medication that was to be administered immediately, for management of the resident's behaviors. No documentation was found that the SDM was contacted to explain the reasons for the use of the drug.

Furthermore, on that same evening, the medication was prescribed and was to be administered every six hours or when needed. No documentation was found in the progress notes until several days later when a discussion occurred regarding the administration of medications with one of the resident children who was not the SDM for personal care .

Sources: resident#001's progress notes and physician orders, and interviews with RPN #105 and other staff. [s. 137. (2)]

Issued on this 31st day of December, 2020

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

Original report signed by the inspector.