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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Oct 11, 2018	2018_739694_0013	031898-16, 002704-17, 003902-17, 008795-17, 018252-17, 021161-17, 023004-17, 024284-17, 024974-17, 000475-18, 021825-18	Critical Incident System

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Lanark Heights Long Term Care Centre
46 Lanark Crescent KITCHENER ON N2N 2Z8

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

AMANDA COULTER (694), ZINNIA SHARMA (696)

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): August 20, 21, 22, 23, 24 30, 31 and September 4, 2018.

During the course of the inspection, the following Critical Incidents were inspected:
log #031898-16, log #023004-17, log #021825, log #024974-17 and log #003902-17 related to Fall Prevention;
log #024284-17 and log # 008795-17 related to resident positioning and transfer; and
log #002704-17, log #018252-17, log #000475-18 and log #021161-17 related to Prevention of Abuse and Neglect.

This inspection was completed in conjunction with complaint inspection #2018_739694_0000 by Long Term Care Homes (LTCH) inspector #694.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care (MOC), Assistant Managers of Care (AMOC), the Life Enrichment Manager, Food Services Manager, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker, Life Enrichment Worker and residents.

During the course of the inspection, the inspectors toured the facility, reviewed resident clinical records, reviewed the facility's policies, annual evaluation of program reviews and training records and residents care and services.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On a certain day in January 2018, a Critical Incident System (CIS) report was submitted by the home stating an allegation of staff to resident abuse.

During an interview, resident #012 told the Long Term Care Homes (LTCH) Inspector that they remembered during a shift they asked staff #121 for their assistance. Staff #121 did not provide the assistance the resident requested.

The clinical records of resident #012 were reviewed and indicated that resident #012 required extensive assistance for most activities of daily living (ADLs). On a certain day in January 2018, it was documented by Registered Practical Nurse (RPN) #114 that the resident requested assistance from staff #121.

RPN #114 was interviewed and stated that on a certain day in January 2018, resident #012 told them that staff #121 did not provide assistance and this left the resident feeling negatively.

The home's investigation notes were reviewed and indicated that after the incident, resident #012 told the Manager of Resident Care (MRC) #101 that they were lying on the soiled bedding and this made them feel humiliated. They also stated that they tried talking to staff #121 after the care was provided but felt that they were being ignored as staff #121 did not respond back to them. The investigation was completed as it revealed that they had inflicted abuse upon resident #012.

MRC #101 told the LTCH Inspector that during their investigation they found that staff #121 was abrupt and unfriendly while providing resident #012 with care and this caused the resident distress. They acknowledged that resident #012 was abused by staff #121.

The home failed to ensure that resident #012 was protected from abuse by staff #121. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: 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 and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home, indicating that on a certain day in October 2017, resident #008 was being transferred using a lift, when part of the lift sling came off and caused the resident to fall.

The clinical record of resident #008 was reviewed and stated that resident required total assistance with two persons physical assist for all their transfers. They required a specific type of lift for all transfers.

During an interview with staff #106, they told the LTCH Inspector that prior to any transfer, staff were to inspect the lift.

On a certain day in August 2018, staff #107 was interviewed by LTCH Inspector and stated that they were one of the staff member who was assisting with the transfer when resident fell on a certain day in October 2017. They acknowledged that they did not check all parts of the lift prior to the transfer.

The home's policy titled "Lifts, Transfers and Repositioning", with a revised date of April 14, 2018, directed staff to check all parts of the mechanical lift before a transfer.

Manager of Resident Care (MRC) #101 and Assistant Manager of Resident Care #113 told the LTCH Inspector that it was their expectation that both staff members who were performing the transfer were responsible for checking the lift. They both acknowledged that safe transferring devices and techniques were not used by staff while they were transferring resident #008.

The home has failed to ensure that staff used safe transferring and positioning devices and techniques when assisting resident #008. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (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; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (b) should clearly set out what constituted abuse and neglect.

On a certain day in August 2018, MRC #101 provided the LTCH Inspector with their current policy to promote zero tolerance of abuse and neglect of residents.

The home's policy titled "Resident Abuse and Neglect", last revised on July 9, 2018, was reviewed. There was no description or definition in the policy that would clearly set out what constituted neglect.

During an interview with the Administrator #100, they stated that this was their most current policy on Abuse and Neglect and all staff members had access to this policy electronically. They were aware that policy to promote zero tolerance of abuse and neglect of residents should include what constituted neglect.

Administrator #100 reviewed their policy along with the LTCH Inspector and acknowledged that their current policy in the home did not clearly set out what constituted neglect.

The licensee has failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents clearly set out what constituted neglect. [s. 20. (2)]

Issued on this 6th day of November, 2018

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

Original report signed by the inspector.