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
Jul 17, 2020	2020_771609_0011	001187-20, 003856-20	Complaint

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake
3 Kirkland Street West Postal Bag 1757 KIRKLAND LAKE ON P2N 3P4

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

Teck Pioneer Residence
145A Government Road East Postal Bag Service 1757 KIRKLAND LAKE ON P2N 3P4

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

CHAD CAMPS (609), KEARA CRONIN (759)

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): July 6-10, 2020.

The following intakes were inspected upon during this Complaint Inspection:

-Two intakes related to complaints submitted to the Director regarding allegations of improper care of residents.

A Critical Incident System (CIS) inspection #2020_771609_0012 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Assistant Director of Care/Staff Educator (ADOC), Office Manager, Physician, Nurse Practitioner, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) residents and their families.

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, reviewed relevant health care records, training logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's Substitute Decision-Maker (SDM) had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director, which outlined how a specific intervention had been discontinued for resident #001 without notifying their SDM.

During an interview with resident #001's SDM, they outlined to Inspector #609, how the home did not inform them that the specified intervention had been discontinued, nor did they participate in decision to discontinue the specified intervention.

A review of resident #001's plan of care found that the specified intervention was discontinued on a particular day.

A review of resident #001's health care records outlined in a progress note, that while visiting the resident, their SDM found out that the specified intervention had been discontinued.

A further review of resident #001's progress notes found that on a particular day, the DOC had discontinued the specified intervention related to the resident's responsive behaviours towards other residents.

A review of the home's policy titled "Nursing Care Planning" last reviewed May 2020 indicated that the resident's representative shall be encouraged and supported to participate in the evaluation of the resident's plan of care and outcomes of care and services.

During an interview with the DOC, they outlined how on the morning of a particular day, they met with the registered and personal support staff and made the decision to discontinue resident #001's specified intervention because of the resident's responsive behaviours towards other residents. The DOC verified that the resident's SDM did not participate in the decision to discontinue the specified intervention, nor informed them at the time that that the specified intervention was discontinued. [s. 6. (5)]

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 the resident, the resident's SDM, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 30th day of July, 2020

[redacted]

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

Original report signed by the inspector.