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 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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2018	2018_679638_0018	006311-18	Complaint

Licensee/Titulaire de permis

Lakeland Long Term Care Services Corporation
6 Albert Street PARRY SOUND ON P2A 3A4

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

Lakeland Long Term Care Services
6 Albert Street PARRY SOUND ON P2A 3A4

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

RYAN GOODMURPHY (638)

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 15 - 20 and 22 - 26, 2018.

The following intakes were inspected during this Complaint inspection:
-One log was a complaint submitted to the Director which was related to allegations of staffing shortages impacting resident care and improper transferring techniques.

A Follow Up inspection #2018_679638_0017 and a CIS inspection #2018_679638_0019, were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aids and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and relevant health care records.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

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	Legendé 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined

by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director related to staffing shortages in the home. The complaint alleged that due to short staffing, staff were unable to complete all resident care which posed a risk to resident safety and well being.

Inspector #638 reviewed the home's "Daily Staffing Compliment" for the month September 2018, and selected three dates in which the home worked short a PSW on at least one home area. Inspector #638 reviewed the scheduled bathing days for the residents on each unit along with the Point Of Care (POC) documentation report related to bathing. Upon review, the Inspector identified that resident #009, #014, #015, #016, #017, #018, #019, #020, #021, #023, #024, #025, #026, #027 and #029 were scheduled to be bathed during one of the selected dates and had their scheduled choice of bathing documented as "Activity Did Not Occur". The Inspector also identified resident #022 and #028 had no documentation to identify if they received their scheduled care or not, related to bathing.

The Inspector reviewed each identified residents' progress notes and POC documentation related to bathing, to identify why the resident's bathing choice was not provided and whether or not the care was made up on another shift. The Inspector was unable to identify any notations with supporting rationale why the scheduled care had not been completed. The Inspector was also unable to identify in the POC documentation report or progress notes any documentation to support that the care was completed during a subsequent shift, prior to these residents' next scheduled bathing time.

In an interview with Inspector #638, PSW #102, PSW #104, PSW #107, PSW #112 each identified that the home frequently worked short at least one PSW in the home during their shifts and this occurred a few times each week. Each of the PSWs identified that bathing was generally the first care that was put to the wayside when the PSWs worked short. PSW #107 and PSW #112 both identified that they tried to complete all required care for bathing when short staffed, but couldn't always get all of the residents' done. The PSWs stated they would communicate any care related to bathing to registered staff and to the next shift in an attempt to ensure care was completed. PSW #112 stated that it was not likely the care related to bathing would be made up prior to the resident's next scheduled bathing time. PSW #112 identified that when staff document care in the POC records as "Activity Did Not Occur" it meant that the care was not provided.

During an interview with Inspector #638, RPN #105 and RPN #111 stated that the home

does work short a PSW in at least one home area a few times per week. Both RPNs identified that scheduled bathing routines generally went by the wayside when short staffed. RPN #105 indicated that when a resident's scheduled care for bathing was missed, it was not likely made up until their next scheduled care related to bathing. RPN #111 acknowledged there were times where they were short staffed and could not complete all required care, but when they were short only one PSW on a unit, the care expectations (including bathing) were still realistic for each resident. RPN #111 identified there have been occasions where direct care staff have stated that because they were short staffed, they would not be completing care related to bathing on their shift, without first attempting to complete care. The Inspector reviewed the POC documentation records with the RPN who stated that "Activity Did Not Occur" appeared to mean that the care was not attempted and that the resident didn't receive their scheduled care.

The home's policy titled "Personal Hygiene, Grooming, Dressing, and Bathing - RSL-ADL-005" last reviewed July 2017, indicated that Lakeland LTC shall ensure that each resident of Lakeland LTC is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements. Bathing includes tub baths, showers and full body sponge baths. The policy identified that care completed will be documented by the PSW in the resident's electronic chart and that any missed care related to bathing required documentation to identify the missed care and was to be rescheduled.

In an interview with Inspector #638, the DON indicated that when the home worked short staffed PSWs, bathing frequently went by the wayside. The DON indicated a plan was developed to ensure that missed care related to bathing was made up as soon as possible to ensure that scheduled care was not completely missed. The DON identified that staff were supposed to document care as provided or not provided in the electronic POC records. The Inspector reviewed the aforementioned dates with the DON, including which residents were scheduled to have their care related to bathing and the documented POC responses. Upon review the DON indicated that it was still reasonable to complete care based on the staffing levels on these shifts and that staff should have attempted care even if short staffed and if not, documented rationale as to why the care was not completed. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 31st day of October, 2018

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

Original report signed by the inspector.