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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2019	2019_671684_0009	026435-18, 003791-19	Critical Incident System

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

SHELLEY MURPHY (684)

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): March 4-8, 2019.

The following intakes were inspected during this Critical Incident (CI) Inspection:

-One Log related to falls prevention; and,

-One Log related to alleged resident to resident abuse.

A Critical Incident Inspection #2019_671684_0010 for Lakeland Long Term Care (Eldcap) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A Critical Incident (CI) Report was submitted to the Director on a specified date in 2018, for an incident that caused an injury to the resident. The CI report indicated that resident #001 acquired an injury during an incident. Resident #001 was admitted to the hospital for the injury.

During review of the care plan for resident #001, Inspector #684 noted the following three care plan foci which provided differing instructions regarding the interventions to be put in place:
1) Sleep and Rest - specified intervention was to be used at night.
2) Dressing - specified intervention was only to be used at night.
3) Falls/Balance - specified intervention was to be used during the day and night.

Inspector #684 reviewed the home's policy "Care Plan - Assessment/Documentation" RLS-DOC-045, last reviewed December 2018, which states: "LLTC shall ensure that the care plan sets out,
-The planned care for the resident; and
-Clear directions to staff and others who provide direct care to the resident".

Inspector #684 interviewed RPN #103 who stated resident #001 sometimes used a specified intervention at night. RPN #102 and PSW #105 both stated resident #001 used the intervention all the time. PSW #106 stated resident #001 only used the intervention at night.

Inspector #684 reviewed resident #001's care plan with RPN #107. RPN #107 stated that the care plan was conflicting, as it stated to use the intervention only at night under Sleep and Rest, and Dressing foci, and then under the Falls/Balance foci it stated, to use the intervention during day and night.

During an interview held with the DOC regarding resident 001's care plan and the use of the specified intervention, the DOC reviewed resident #001's care plan and stated that it needed to be updated to provide clarity to staff. The care plan was not clear on when the intervention was to be used for resident #001 as currently the care plan reflects two different times. [s. 6. (1) (c)]

Issued on this 12th day of March, 2019

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

Original report signed by the inspector.