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

Sudbury Service Area Office
159 Cedar Street Suite 403
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159, rue Cedar Bureau 403
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 31, 2021	2021_824736_0005	023318-20, 023328-20	Follow up

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

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 15-19, 2021.

During the course of the inspection, the following logs were inspected:
-one log related to compliance order (CO) #001 from inspection #2020_565647_0020, ensuring that the home was compliant with s. 36 of the Ontario Regulations (O.Reg) 79/10, specifically ensuring that staff used safe lifts and transfer devices for residents, with a compliance due date (CDD) of February 19, 2021;
-one log related to CO #001 from inspection #2020_565647_0018, ensuring that the home was compliant with s. 33(1) of the O.Reg 79/10, specifically ensuring that residents #006, #007, and #008 were bathed at a minimum, twice a week by the method of their choice, with a CDD of February 5, 2021.

A Critical Incident Inspection #2021_824736_0006 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Compliance Order (CO) related to s. 36 of the Ontario Regulations 79/10, and non-compliance of a Voluntary Plan of Correction (VPC) related to s. 6(9) of the LTCHA 2007, were identified in inspection #2021_824736_0005, which was conducted concurrently with this inspection, and have been issued in this inspection report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Associate Director of Nursing (ADON), acting Associate Director of Nursing (acting ADON), the Infection Prevention and Control lead, Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), an Occupational Therapist from West Parry Sound Health Centre (WPSHC) and residents.

The Inspector also conducted a tour of resident care areas, reviewed relevant health care records, licensee policies, audits and educational records, and observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 33. (1)	CO #001	2020_565647_0018	736

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 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 the resident.

During the inspection, a Personal Support Worker (PSW) informed a Registered Practical Nurse (RPN), that the transferring device required to transfer the resident was not available, and that they were going to proceed to use a different transferring device to assist the resident.

Approximately one month prior, the resident was assessed by the Physiotherapist, and it was documented in progress notes that the resident was not safe to use the other transferring device, as there was risk of injury to the resident.

In separate interviews with the PSW, and the RPN, they indicated that the transferring device the resident required was to be shared, and that as a result, residents had to wait to receive care. The PSW indicated that staff opted to use the other transferring device to assist the resident, so the resident would not have to wait for care.

In an interview with the PSW, they indicated that they were aware the resident was to use the specific transferring device, however, the PSW chose to use the other transferring device to transfer the resident. The PSW indicated that they should have used the correct transferring device for the resident.

Sources: The Critical Incident Report; internal investigation notes; the resident’s care plan and progress notes; interviews with the PSW, the RPN, and other staff; licensee policy titled "Lift Transfers Resident Centred Safe Lift Program", last reviewed February 12, 2021. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”. DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out for three residents was documented.

a) A review of the first resident's documentation in Point Of Care (POC), indicated that care provided to the resident, including activities of daily living (ADLs) were not documented nine times during the first month of review; and twice during the second month of review.

In an interview with the DON, they reviewed the resident's POC documentation and indicated that the charting was not completed, and care was not documented as provided.

Sources: The resident’s POC documentation; interview with DON, and other staff; licensee policy titled “Personal Hygiene, Grooming Dressing and Bathing”, Index ID RSL-ADL-005, last reviewed December 2020.

b) A review of the second resident's documentation in POC, indicated that care provided to the resident related to ADLs was not documented 10 times during the first month of review, and six times during the second month of review.

In an interview with the Registered Nurse (RN), they indicated that staff were to record the care provided on the resident’s POC. Together the RN and Inspector reviewed the resident’s POC documentation, and the RN indicated that the care provided was not documented.

Sources: The resident's POC documentation; interview with the RN and other staff; licensee policy titled “Personal Hygiene, Grooming Dressing and Bathing”, Index ID RSL-ADL-005, last reviewed December 2020.

c) The Inspector reviewed the POC documentation for the third resident for the two months of review.

The Inspector noted that in first month of review, documentation of care was not completed on 21 times during the first month of review, and twice during the second month of review.

During an interview with the DON, the Inspector and DON reviewed the resident’s POC documentation, and the DON indicated to the Inspector that care was not documented as provided for the resident in two months reviewed, and should have been.

Sources: The resident's POC documentation; interview with DON and other staff; licensee policy titled “Personal Hygiene, Grooming Dressing and Bathing”, Index ID RSL-ADL-005, last reviewed December 2020. [s. 6. (9) 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 care is documented as provided, to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.

Ontario

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) : AMANDA BELANGER (736)

Inspection No. / No de l’inspection : 2021_824736_0005

Log No. / No de registre : 023318-20, 023328-20

Type of Inspection / Genre d’inspection: Follow up

Report Date(s) / Date(s) du Rapport : Mar 31, 2021

Licensee / Titulaire de permis : Lakeland Long Term Care Services Corporation
6 Albert Street, Parry Sound, ON, P2A-3A4

LTC Home / Foyer de SLD : Lakeland Long Term Care Services
6 Albert Street, Parry Sound, ON, P2A-3A4

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Steve White

To Lakeland Long Term Care Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2020_565647_0020, CO #001;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must comply with s. 36 of O. Reg. 79/10.

The licensee shall prepare, submit, and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The plan must include, but is not limited to, the following:
1) How the home will ensure that equipment is available to staff to use for resident transfers,
2) How the home will ensure that if lift equipment is not available for staff, staff will be aware of the correct, and safe methods to lift and transfer a resident, and
3) How the home will ensure that all staff use safe transferring and positioning devices or techniques when assisting residents.

Please submit the written plan, quoting Inspection #2021_824736_0005 by April 16, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

During the inspection, a Personal Support Worker (PSW) informed a Registered Practical Nurse (RPN), that the transferring device required to transfer the resident was not available, and that they were going to proceed to use a different transferring device to assist the resident.

Approximately one month prior, the resident was assessed by the Physiotherapist, and it was documented in progress notes that the resident was not safe to use the other transferring device, as there was risk of injury to the resident.

In separate interviews with the PSW, and the RPN, they indicated that the transferring device the resident required was to be shared, and that as a result, residents had to wait to receive care. The PSW indicated that staff opted to use the other transferring device to assist the resident, so the resident would not have to wait for care.

In an interview with the PSW, they indicated that they were aware the resident was to use the specific transferring device, however, the PSW chose to use the other transferring device to transfer the resident. The PSW indicated that they should have used the correct transferring device for the resident.

Sources: The Critical Incident Report; internal investigation notes; the resident's care plan and progress notes; interviews with the PSW, the RPN, and other staff; licensee policy titled "Lift Transfers Resident Centred Safe Lift Program", last reviewed February 12, 2021.

An order was made by taking the following factors into account:

Severity: The resident was transferred by using an incorrect lift, resulting in actual risk of harm to the resident.

Scope: The scope of this non-compliance was isolated, as it only involved one resident being transferred by staff not using safe transferring or positioning devices or techniques when they assisted one out of three residents reviewed during this inspection.

Compliance History: The licensee continues to be in non-compliance with O. Reg. 79/10, s. 36, resulting in a compliance order (CO) being re-issued. CO #001 was issued on November 20, 2020 during inspection #2020_565647_0019), and amended on February 5, 2021, with a compliance due date of February 21, 2021, and CO #001 was issued on July 30, 2020

(inspection # 2020_565647_0006) with a compliance due date of August 31, 2020. In the past 36 months, four other COs were issued to different sections of the legislation, all of which have been complied. (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 14, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of March, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amanda Belanger

Service Area Office / Bureau régional de services : Sudbury Service Area Office