Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
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Original Public Report

Report Issue Date: August 24, 2023	
Inspection Number: 2023-1441-0003	
Inspection Type: Critical Incident System	
Licensee: Lakeland Long Term Care Services Corporation	
Long Term Care Home and City: Lakeland Long Term Care Services, Parry Sound	
Lead Inspector Jennifer Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2023.09.08 12:01:44 -04'00'
Additional Inspector(s) Shelley Murphy (684) Jean-Pierre Nabarra de Bénéjacq (000702)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17- 21, 2023.

The following intake(s) were inspected:

- One Intake related to a missing controlled substance.
- Two Intakes related to an alleged abuse.
- Two Intakes related to Improper/incompetent care of resident by staff.
- One Intake related to Medication incident/adverse drug reaction to resident by staff.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Lifts and Transfers

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg 246/22, s. 40

1) The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident experienced an unsafe technique while being transferred by staff.

A review of the investigation notes, and an interview with the Assistant Director of Care (ADOC) indicated that the staff did not follow the home's policy while assisting the resident with a transfer.

Sources: Critical Incident (CI) report; Interviews with the ADOC and other staff, review of investigation notes; record review of the resident's care plan, and their electronic medical record; home's policy titled, "Lift Transfers Resident Centered Safe Lift Program", last reviewed June 2, 2023; home's policy titled, "Nursing Support Aide", last reviewed October 18, 2022.

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2) The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident was discovered by a staff member after sustaining an unwitnessed fall.

In an interview with the ADOC, they indicated that when a resident has fallen, the staff were to ensure proper lifting procedures were performed. The ADOC indicated that the staff did not use safe transferring when assisting the resident.

Sources: CI report, a resident's progress notes, and assessments; the home's investigation notes; home's policy titled, "Lift Transfers Resident Centered Safe Lift Program", last reviewed June 2, 2023; interviews with the ADOC, and other staff.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary

The progress notes for a resident, and a medication incident report showed that the resident received medications that were not prescribed for them.

During an interview with the ADOC they acknowledged that the medication incident had occurred.

The risk to the resident was moderate as they received medications that were not prescribed to them.

Sources
CIS report, a resident's progress notes, medication incident report, observing medication administration for the resident.

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