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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2014	2014_332575_0003	S-000365-12, S-000581-12	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 CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

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

LINDSAY DYRDA (575)

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): April 8, 9, 2014

The inspector conducted the inspection in both the ELDCAP unit (Facility #2966) and the Long-Term Care unit (Facility #2958).

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nursing Staff, Personal Support Workers (PSW), Quality Management Coordinator, and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, observed staff to resident interactions, the provision of care to residents,
reviewed resident health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. On April 9, 2014 inspector #575 reviewed health care records for Resident #001.

According to the Critical Incident, the resident sustained a fall and was transferred to hospital where it was confirmed the resident had sustained a fracture. The resident had surgery and returned to the home 10 days later. On April 9, 2014 inspector #575 interviewed the ADOC who stated that a full RAI MDS assessment is completed if there is any significant change in the resident's care on return from hospital. The ADOC confirmed that the full RAI MDS assessment for Resident #001 was not completed on return from hospital when there was a significant change.
On April 9, 2014 inspector #575 reviewed the home's Falls Prevention Policy last revised October 2013. The policy indicates that staff are to complete a level of risk for falling assessment upon return from hospital admission. The licensee did not ensure that the Falls Prevention Policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. On April 11, 2014 inspector #575 reviewed incident notes for Resident #002 over a period of 16 months in 2012 and 2013. The resident had a total of 12 falls during this time period and only one post falls assessment and neuological assessment was completed. According to the Falls Prevention Policy, last revised October 2013, a neurological assessment is to be initiated for any unwitnessed fall or if a head injury is apparent. An interview with the ADOC on April 8, 2014 confirmed that a neurological assessment and a post falls assessment is to be completed by staff for any fall. The ADOC confirmed that the post falls assessment tool was introduced in March 2012.
On April 11, 2014 inspector #575 reviewed the incident report for Resident #002 for a fall in 2012. The incident report stated that the resident was assisted up in a chair by a PSW before the RPN arrived to complete the assessment. The Falls Prevention Policy states that a registered staff must complete a thorough physical assessment before the resident is moved. The licensee did not ensure that the Falls Prevention Policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. On April 8, 2014 inspector #575 reviewed the health care records for Resident #003. The progress and doctor notes indicate that the resident had an unwitnessed fall. The most recent Falls Prevention Policy revised October 2013 was reviewed by the inspector on April 8, 2014. The policy states that all falls are to be documented on an incident report and a neurological assessment shall be initiated following an unwitnessed fall. Additionally, the authorized representative of the resident shall be notified within 24 hours of the incident. The health care records confirmed that no incident report or neurological assessment was completed, and the substitute decision maker (SDM) was not contacted. On April 9, 2014 inspector #575 interviewed staff member #900. The staff member stated that a neurological assessment must be implemented for all unwitnessed falls. Approximately one week later, the resident

sustained another unwitnessed fall. The incident report states that the SDM is to be notified during the next shift. The inspector reviewed the progress notes for a 2 week period following the incident. The SDM was never notified of the incident. The licensee did not ensure that the Falls Prevention Policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 ensuring that the home's Falls Prevention Policy is complied with, to be implemented voluntarily.

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On April 8, 2014 inspector #575 reviewed Resident #001's most recent care plan. The care plan indicates that staff are to check the resident every 30 minutes. On April 9, 2014 inspector #575 interviewed staff member #700 who was not aware of any 30 minute checks to be completed on this resident. On April 9, 2014 inspector #575 interviewed staff member #500 who stated that Resident #001 does not require 30 minute checks. On April 9, 2014 inspector #575 interviewed the ADOC who stated that 30 minute checks would be indicated in the care plan and documented on the 30 minute check sheets. The ADOC stated that the home is not always documenting every 30 minute checks. On April 9, 2014 the inspector reviewed the resident's health care record and confirmed that 30 minute checks have not been documented for Resident #001. The licensee did not ensure that the care set out in the care plan was provided to Resident #001 as specified in the plan. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. On April 8, 2014 inspector #575 completed an audit of the Falls Prevention Program staff training records for 2013 and 2014. The training records were compared to the current staff list provided by the home. Training for direct care staff including PSWs, RPNs, and RNs was reviewed. It was determined that only 31/77 or 40.3% of PSWs, 9/23 or 39.1% of RPNs, 0/7 or 0% of RNs had falls prevention training within the last year. Only 40/107 or 37.4% of direct care staff had falls prevention training according to the home's records. The licensee failed to ensure that direct care staff receive annual training in the Falls Prevention Program. [s. 221. (2) 1.]

Issued on this 17th day of April, 2014

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