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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 28, 2015	2015_376594_0007	S-000696-15, S-000387-14	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

MONIKA GRAY (594)

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 04-06, 2015

This inspection was conducted concurrently with Follow Up Inspection 2015_376594_0005 and Complaint Inspection 2015_376594_0006.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Behaviour Restorative Team (BRT) Clinical Lead, Registered Practical Nurses (RPNs), Social Service Manager, and the Assistant Director of Nursing (ADON).

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted daily walk through of the resident care areas, and observed staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every suspected incident of abuse of a resident by anyone is immediately investigated. In a Critical Incident Report to the Director dated January 2015, the licensee stated that on a day in January 2015, a resident was found to have had a minor injury and it may have been caused by the actions of a co-resident, or who may have otherwise contributed to the injuries. The resident had just been previously seen leaving a common room area where the co-resident, who has responsive behaviours, was known to have been.

According to the same report it was stated that the circumstances that led to the resident sustaining the minor injury were not witnessed, and as there was no supporting indication that an altercation had occurred (i.e the resident did not yell out – as they are known to do if approached by a co-resident) it was determined that the minor injury could not be attributed with certainty, directly to the co-resident and so the family were not notified of the incident.

The inspector requested the investigation notes from the Social Services Manager, (acting Administrator at the time of the inspection), who stated they were unable to produce the documentation, but would contact the Administrator and submit the notes to the inspector. The inspector reviewed email documentation from the Administrator which stated that, the Administrator did not feel there was any need to investigate further. The Administrator further stated in the email that, after the incident occurred, the incident was reported at a Risk meeting and given the Administrator's role with the behaviour team, followed up with the: BRT Clinical Lead, Secondary Lead and RPN. Discussion of the incident and strategies to prevent further occurrences with the BRT Clinical Lead, Secondary Lead and RPN occurred.

During an interview with the inspector, the ADON stated the process for investigating suspected or witnessed abuse is as per the home's Abuse policy. The inspector reviewed the home's Abuse Policy #RSL-RR-007, review date of October 2012, which stated investigation will be conducted by the Administrator and/or Director of Nursing and Personal Care. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #011 was based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

In a Critical Incident Report submitted to the Director during January 2015, resident #010 was found to have a minor injury, and while the origin of the injuries were not known, as stated in the report, they may have been caused by the actions of resident #011, or who may have otherwise contributed to the injuries. According to the report submitted to the Director, additional responsive behaviours by resident #011 were listed.

The inspector reviewed resident #011's care plan which failed to identify any responsive behaviours. A review of the resident's progress notes from date of admission, stated the resident has a history of responsive behaviours prior to admission to the long-term care home. Further review of resident #011's progress notes until January 2015, identified additional responsive behaviours as well as involvement by the BRT.

The inspector reviewed the resident's health care record which identified various community agency consultation, assessments and a discharge summary that identified responsive behaviours. Included in the resident's health care record was a Resident Profile and 24-Hour Admission Care Plan identifying responsive behaviours in the last 7 days; that interfere with activities of daily living. The Resident Profile and 24-Hour Admission Care Plan included a hand written note stating a history of responsive behaviours.

The inspector interviewed s#-102 and s#-103. S#-103 identified two responsive behaviours of the resident but was not aware of the care plan addressing this. S#-102 identified one responsive behaviour but had not been provided any guidance or direction relating to interventions regarding this. In an interview with the inspector, s#-101 stated resident #011 had a history of responsive behaviours, and identified a trigger for responsive behaviours which should have been identified on the care plan.

The inspector reviewed the home's Behaviour Care and Supportive Measures Program policy with a review date of October 2014. The policy indicated that the Resident Profile New Admission document provides staff the opportunity to quickly define potential triggers, behaviours, care needs, etc and effective care strategies to address those needs and the content from the documented is to be integrated into the resident's care plan.

Given that: the licensee identified responsive behaviours in the Critical Incident Report to the Director; the resident's health care record contained community agency consultations, assessments, and a discharge summary that identified the resident's responsive behaviours; and the resident's 24-hour Admission care plan identified responsive behaviours, the plan of care failed to be based on these assessments of resident #011. [s. 26. (3) 5.]

2. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included mood and behaviour patterns.

In a Critical Incident Report to the Director, the licensee stated that during January 2015, resident #010 was found to have a minor injury and it may have been caused by the actions of resident #011, or who may have otherwise contributed to the injuries. The inspector reviewed resident #010's progress notes from the period of three months, and

identified over a course of less than one week (four days) the resident was documented as displaying a specific responsive behaviour in four separate progress note entries.

The Quality & Risk Meeting Notes indicated that, the BRT was to follow up with interventions to decrease resident's responsive behaviour. In a follow up progress note it was stated that resident #010 continues to display this behaviour and is difficult to redirect. The inspector reviewed Dementia Observation System (DOS) charting for the period of one week, and identified documentation that four of the seven days the resident was observed displaying the specific behaviour during the day. Review of the ABC charting/Behaviour Record, by the inspector, over the period of two months, identified four incidents of the specific behaviour.

The inspector reviewed the resident's care plan which identified four responsive behaviour problems but failed to identify the specific responsive behaviour or provide interventions for staff to manage this behaviour.

Review of the home's Responsive Behaviours policy with a review date of October 2014 indicated, that when a responsive behaviour such as the behaviour that resident #010 was displaying occurs, the Registered Staff along with the care team (PSW) will determine what is causing the behaviour and if an immediate cause can be found; the care plan will be adjusted accordingly and the resident will be assessed on subsequent shifts to determine the effectiveness. [s. 26. (3) 5.]

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 the plan of care for resident #010, #011, and all other residents is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident, mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to resident #011 who had been demonstrating responsive behaviours. In a Critical Incident Report submitted to the Director on January 2015, resident #010 was found to have a minor injury and while the origin of the injuries were not known, as stated by the in the report, they may have been caused by the actions of resident #011, or who may have otherwise contributed to the injuries. According to the report submitted to the Director, additional responsive behaviours by resident #011 were listed.

The inspector reviewed resident #011's care plan which failed to identify any responsive behaviours. A review of the resident's progress notes from date of admission, stated the resident has a history of responsive behaviours prior to admission to the long-term care home. In an addendum to the admission progress note it was stated that prior to admission, resident #011 displayed a specific responsive behaviour. Further review of resident #011's progress notes until January 2015, identified additional responsive behaviours as well as involvement by the BRT.

The inspector reviewed the resident's health care record which identified various community agency consultation, assessments and a discharge summary that identified responsive behaviours. Included in the resident's health care record was a Resident Profile and 24-Hour Admission Care Plan identifying responsive behaviours in the last 7 days; that interfere with activities of daily living. The Resident Profile and 24-Hour Admission Care Plan included a hand written note stating a history of responsive behaviours.

The inspector interviewed s#-102 and s#-103. Staff s#-103 identified two responsive behaviours of the resident but was not aware of the care plan addressing this. Staff s#-102 identified one responsive behaviour but had not been provided any guidance or direction relating to interventions regarding this. In an interview with the inspector, s#-101 stated resident #011 had a history of responsive behaviours, and identified a trigger for responsive behaviours which should have been identified on the care plan.

Review of the home's Behaviour Care and Supportive Measures Program policy review date October 2014 stated the Resident Profile New Admission document provides staff the opportunity to quickly define potential triggers, behaviours, care needs, etc and effective care strategies to address those needs and the content from the documented is to be integrated into the resident's care plan. [s. 53. (4) (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 to ensure that for resident #011 and all other residents demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm, immediately reported the suspicion and the information upon which it was based to the Director.

In a Critical Incident Report submitted to the Director during January 2015, it was stated a resident was found to have a minor injury and it may have been caused by the actions of a co-resident, or who may have otherwise contributed to the injuries. The inspector reviewed resident #010's progress notes over the course of three months, and an entry on a date in January 2015, indicated that s#-124 observed resident #011 coming out of a

common room with their fists clenched, looking upset and that resident #010 came out of the common room after resident #011 with a minor injury. According to the same progress note, staff would monitor interactions between the two residents. A progress note dated one day later, by s#-120 stated an incident report was to be completed and family to be notified.

As stated in the Critical Incident Report submitted to the Director, the circumstances that led to the resident sustaining the minor injury were not witnessed, and as there was no supporting indication that an altercation had occurred (i.e the resident did not yell out – as they are known to do if approached by a co-resident) it was determined that the minor injury could not be attributed with certainty, directly to the co-resident and so the family were not notified of the incident.

The inspector reviewed an Alleged Abuse Reporting Form which stated, to be completed by anyone who has been subjected to, witnessed or received a report of alleged abuse towards a resident. According to the document the incident was reported to the Nurse Manager by s#-125 and it was stated that s#-125 reported findings (injury) to s#-123 who was acting Nurse Manager at that time. S#-123 directed staff to monitor interactions between resident & alleged co-resident. The inspector noted the document was not signed or dated.

The inspector reviewed the home's Abuse Policy #RSL-RR-007 review date of October 2012 which stated a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, shall immediately report the suspicion and the information to the Nurse Manager immediately and provide the Nurse Manager a written statement utilizing the Alleged Resident Abuse Form. The Nurse Manager will complete the Alleged Abuse Nurse Manager Action Form and present that to the Administrator or Director of Nursing and Personal Care.

The ADON and inspector reviewed the Alleged Abuse Reporting Form and Critical Incident Report to the Director, where the ADON confirmed the Director was not immediately informed of suspected abuse. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to assist and support residents who have been abused or neglect or allegedly abused or neglected. The inspector reviewed the home's Abuse Policy #RSL-RR-007 review date of October 2012 and it failed to identify procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The Social Service Manager and ADON reviewed the policy with the inspector and verified the policy failed to include the above mentioned procedures and interventions. [s. 96. (a)]

2. The licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect. The inspector reviewed the home's Abuse Policy #RSL-RR-007 review date of October 2012 and it failed to identify measures and strategies to prevent abuse and neglect. The Social Service Manager and ADOC reviewed the policy with the inspector and verified the policy failed to identify measures and strategies to prevent abuse and neglect. [s. 96. (c)]

Issued on this 24th day of June, 2015

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

Original report signed by the inspector.