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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2018	2018_565647_0010	006084-18	Complaint

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

JENNIFER BROWN (647), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 9 - 12, 2018

This inspection was related to a complaint the Director received regarding resident bill of rights, prevention of abuse, pain management, plan of care, and drug regimes.

A Critical Incident Report Inspection, #2018_565647_0011 and Follow Up Inspection, #2018_565647_0012, were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Social Service Worker, Behaviour Response Lead, Supervisor of Support Services, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Family Members and Substitute Decision Makers.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they fully respected and promoted the resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential.

A complaint was submitted to the Director, regarding personal health information for resident #003 being found at a local retail outlet. The complainant stated that the home had purchased a device and when they identified having received the wrong device they accidentally packed up the resident's medical information and returned the device to the retail outlet.

Inspector #684 reviewed the home's investigation notes, which identified that the breach of privacy included the following resident information; resident's full name, date of birth, resident ID, name of prescribing physician, expiration date for medication and dosage and product details.

Inspector #684 interviewed Registered staff member #139 who confirmed that the device that was purchased was not appropriate for the required use, and were returning it. The

Registered staff member #139 indicated that the Administrator came and removed the device.

During an interview with the Administrator they stated they went to a local retail store to purchase a device that would be used for the resident's needs. Once purchased, staff discovered that a proper device was required instead of the above mentioned device. The Registered staff member #139 bundled what they thought needed to go back to the store without knowing that they had picked up and brought the medical information of resident #003, along with the device and packaging to the Administrator. It was when an employee of the retail store was checking the returned device that the personal health information was discovered. This employee then contacted the family of the resident to make them aware of what they had found. The Administrator informed Inspector #684 that they reported the breach of privacy to the Privacy Commissioner of Ontario.

During an interview with Registered staff member #139 regarding resident privacy they stated the following would be how they ensure privacy and confidentiality for the residents in the home:
-Not providing information unless written consent was given by the Substitute Decision Maker (SDM),
-Privacy when providing care, such as divider curtains being drawn, shutting doors, and blinds pulled down,
-Charts are only to be accessed by staff unless consent was obtained.

Inspector #684 reviewed the following policy: Policy for Privacy and Release of Records 4.25 ADM-O.P. last reviewed December 2017, which stated, Lakeland Long-Term Care (LTC) is committed to respecting and protecting the privacy of all residents who live in the Home. As a result, Lakeland will adhere to Ministry of Health and Long Term Care (MOHLTC), the Personal Health Information Protection Act (PHIPA) and the Personal Information Protection and Electronic Documents Act (PIPEDA) legislation regarding privacy and release of the records of our residents.

Inspector #684 reviewed the Privacy Breach Information Report which was sent to the Privacy Commissioner of Ontario.

The Acting Director of Care (DOC) confirmed to the Inspector that there was a breach of privacy information for resident #003. [s. 3. (1) 11. iv.]

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 they fully respected and promoted the resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential, to be implemented voluntarily.

Issued on this 18th day of April, 2018

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

Original report signed by the inspector.