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
Oct 31, 2018	2018_679638_0019	002439-18, 006078-18, 008021-18, 013085-18, 016904-18, 027671-18	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
6 Albert Street PARRY SOUND ON P2A 3A4

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

RYAN GOODMURPHY (638)

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): October 15 - 19 and 22 - 26, 2018.

The following intakes were inspected during this Critical Incident System (CIS) inspection:
-One log was related to a critical incident the home submitted to the Director regarding missing narcotics;
-One log was related to a critical incident the home submitted to the Director regarding improper transferring techniques;
-One log was related to a critical incident the home submitted to the Director regarding alleged improper care and transferring techniques;
-One log was related to a critical incident the home submitted to the Director regarding a fall in which the resident was taken to hospital as a result of a fracture;
-One log was related to a critical incident the home submitted to the Director regarding resident rights and transferring techniques; and
-One log was related to a critical incident the home submitted to the Director regarding the management of responsive behaviours and resident rights.

A Follow Up inspection #2018_679638_0017 and a Complaint inspection #2018_679638_0018, were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aids and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs, relevant training and health care records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Personal Support Services
Responsive Behaviours

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

- **2 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 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 residents.

A CIS report was submitted to the Director related to an incident where PSW #106 allegedly transferred resident #001 using a transferring technique that put the resident's safety at risk on a specific date in September 2017.

Inspector #638 reviewed resident #001's health care records and identified in the resident's care plan (in effect at the time of the incident) that the resident required specific assistance and interventions when transferring the resident. The Inspector reviewed the internal investigation notes and identified a disciplinary letter addressed to PSW #106 which identified the home found the PSW did not provide care according to the resident's documented plan of care and violated the home's safe lift and transfer policy.

In an interview with Inspector #638, PSW #104 indicated that they were working with PSW #106 on the date of the incident and identified the PSW approached them and stated that they had done the resident transfers contrary to their assessed needs. PSW #104 stated that resident #001 demonstrated specific responsive behaviours and required specific assistance and interventions when transferring the resident and PSW #106's actions were not acceptable.

During an interview with the Inspector, RPN #105 indicated that direct care staff referred to a resident's care plan or transfer card on the resident's wall for specifics related to transfer status and interventions. The RPN indicated that residents who used a specific transferring intervention had that direction identified in the resident's care plan.

The home's policy titled "Lifts & Transfers - Resident Centred Safe Lift Program" last reviewed October 2017, indicated proper transferring techniques specific to the care the resident required.

In an interview with Inspector #638, the DON stated staff referred to a resident's care plan and transfer logo at the bedside for specific transfer interventions. The DON indicated that PSW #106 was not following resident #001's assessed requirements in this circumstance. [s. 36.]

2. A CIS was submitted to the Director related to an incident where PSW #103 allegedly using the wrong transfer device for resident #002, despite knowing it was the wrong device. PSW #100 reported that the device was not appropriate for the resident and the resident required intervention by the PSW to ensure their safety while being transferred.

Inspector #638 reviewed resident #002 clinical records at the time of the incident, which indicated that resident #002 required specific interventions during their transfers and was to be using a specific transferring intervention. The Inspector reviewed the home's investigation notes related to the incident, during which PSW #103 admitted to using the wrong device and regretted their actions. The home determined that PSW #103 violated the resident's right to receive care consistent with their assessed needs and documented plan of care.

During an interview with Inspector #638, PSW #100 indicated that each resident was assessed for their lift and transfer status and for the appropriate devices to use with the transfer. The PSW stated that the information related to specific interventions was located in the resident's care plan and on the wall behind resident's bed. PSW #100 stated that the correct device must be used for each resident transfer based on their assessed interventions.

Inspector #638 interviewed PSW #103 regarding the incident. The PSW stated that there was a different devices in resident #002's room instead of the device assessed for their needs, so they determined that the device in the room was probably already used on that resident and used it again instead of locating the proper device for the resident. PSW #103 indicated that all staff were expected to use the proper device as per the assessments completed by the physiotherapy department.

During an interview with Inspector #638, RPN is #105 confirmed that each resident is assessed individually for their transfer status and transfer device. RPN #105 confirmed that it is the expectation of all direct care staff that they use the correct device for every transfer.

A review of the policy titled "Lifts & Transfers - Resident Centred Safe Lift Program", last reviewed October 2017, indicates that proper transfer methods and devices that were specific to resident #002's assessed needs.

Inspector #638 confirmed with the DON during an interview that in the incident involving resident #002, the care provided was not based on the assessed interventions laid out within the resident's plan. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting resident #002 and any other resident requiring assistance, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A CIS report was submitted to the Director where PSW #109 attempted to provide care to resident #003 who verbally refused the PSWs advances and the resident was observed using body language to indicate their refusal of care. The CIS report also identified that PSW #109 was allegedly overheard stating a demeaning comment within earshot of other residents.

Inspector #638 reviewed the home's investigation and identified that PSW #109 acknowledged that they responded with a specific statement while attempting to assist resident #003. The investigation identified that the PSW regretted their comments and should not have said that comment. The report identified that management reviewed camera footage of the incident and found that the resident was refusing the PSWs advances for care.

In an interview with Inspector #638, PSW 107, who was assisting PSW #109 with resident #003's care at the time of the incident, indicated that PSW #109 was attempting to provide care to the resident and when the resident became resistive to care, the PSW responded with a specific statement.

Inspector #638 interviewed PSW #109 (who provided care to resident #003 at the time of the incident) who stated that their approach was an attempt to complete care and although the resident refused, the PSW didn't want the resident to go any longer without care. The PSW acknowledged that their actions were not appropriate and they should have waited until the resident was receptive.

In an interview with Inspector #638, the DON indicated that they could see how PSW #109's approaches with resident #003 infringed upon the resident's rights and staff knew to attempt to balance the resident's rights to dignity with their approaches to complete resident care. [s. 3. (1) 1.]

Issued on this 31st day of October, 2018

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

Original report signed by the inspector.