Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 19, 2021	2021_772691_0003	023249-20, 024882-20	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

JENNIFER NICHOLLS (691), KEARA CRONIN (759)

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): January 25-29, 2021.

The following intakes were inspected upon during this Critical Incident System Inspection:

-One intake submitted to the Director regarding an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

-One intake submitted to the Director regarding resident to resident abuse.

A Follow up Inspection (2021_772691_0002) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Infection Prevention and Control Lead, Behavioral Support Team, Environmental Services Team Members, Personal Support Worker (PSWs), Nursing Service Aides (NSAs), and residents.

The Inspector (s) also conducted a daily tour of resident care areas, observed the provision of care to residents, observed staff to resident interactions, observed Infection Prevention and Control practices, reviewed relevant health care records, internal investigation notes, staff education records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Responsive Behaviours

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

3 WN(s)
2 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	Légende 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to minimize the risk of potential harmful interactions of the resident by identifying and implementing interventions.

A. A resident who was known to have responsive behaviors, was involved in altercation with a resident. Following the incident, a new intervention was added to the resident's care plan, which instructed the staff how to monitor and respond to the resident to prevent further incidents.

B. Upon further review of the resident's clinical records, it was identified due to increased behaviors of the resident, there was an additional intervention related to staff to resident monitoring to prevent further incidents from this resident. The Inspector was unable to identify the additional intervention related to staff to resident monitoring for the resident. It was further confirmed that there was no staff providing the additional intervention related to staff to resident monitoring the residents at the time.

Sources: Inspector’s observations; resident’s progress notes and care plan; interviews with the Behavioral Supports Ontario (BSO) Clinical Lead, Director of Care (DOC), and other staff. [s. 54. (b)]

2. The licensee has failed to ensure that the resident’s responsive behaviour care plan identified potential risks and interventions to prevent harmful interactions between other residents.

Triggers for a resident's responsive behaviours were identified through progress notes/interviews, but these triggers were not included in the resident's care plan.

Sources: A resident's care plan and progress notes; interview with the BSO Clinical Lead, and other staff. [s. 54. (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 shall ensure that steps are taken to minimize the risk of altercations potentially harmful interactions between and among residents, by identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

In accordance with Directive #3 for Long-Term Care Homes under the Long- Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, long-term care homes were required to isolate re-admissions under droplet and contact precautions for 14 days. The home’s policy further indicated that all staff were to use the appropriate Personal Protective Equipment (PPE) while providing care to residents, including gloves and gowns.

During observations, the Inspector observed a staff member in a room that had signage indicating that the resident was on droplet and contact isolation precautions. The staff member was observed not wearing a gown or gloves while providing physical assistance to the resident.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, licensee's policy titled "Additional Precautions- Droplet Transmission and Droplet Precautions", last reviewed December, 2019. [s. 229. (4)]

2. The licensee failed to ensure that a hand hygiene program was implemented related to staff assisting residents with hand hygiene before and after meals.

A) During meal observations, the Inspector observed that the resident’s hands were not cleaned before and after lunch. A review of the home’s hand hygiene routine practices included a process for staff to assist residents to clean their hands before and after a meal. The home’s hand hygiene program was based on the “Just Clean your hands” program which required that staff assist residents to clean their hands before and after meals.

B) During meal observations, the Inspector observed the Personal Support Workers (PSWs) enter the dining room without preforming hand hygiene and assisting residents with their meals. The Inspector also observed one of the staff removing dirty dishes and not preforming hand hygiene prior to serving lunch meals to residents.

The home's hand hygiene program required that staff were to clean their hands before preparing, handling or serving food.

Sources: Observations of residents in the identified dining room, interviews with the DOC, the Registered Practical Nurse (RPN) and other staff, the home’s policy "IPAC-Hand Hygiene” Routine practices last revised December 16, 2019, and “Just Clean Your Hands” program resources, included in policy references. [s. 229. (4)]

3. The licensee has failed to ensure that staff participated in the implementation of the (IPAC) program specifically related to ensuring that appropriate signage was posted on or near the entrance door of affected residents that indicates that the resident was on additional precautions to prevent transmission of infection.

The Inspectors noted that two residents had (PPE) supplies outside their doors with no signage posted indicating specific additional precautions required.

As per the home's policy, they should have posted appropriate additional precautions (IPAC) signage to ensure proper use of (PPE) to protect staff and other residents in the home at risk of disease transmission.

Sources: Inspector observations; COVID-19 Directive #3 for Long-Term Care Homes effective October 16, 2020; Licensee's policy titled "Additional Precautions- Initiation and

Discontinuation for additional precautions", last reviewed December, 2019; the resident's admission/readmission information; and interviews with the DOC and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that Critical Incident System (CIS) report was submitted on time as required by the Director.

A CIS report was submitted to the Director for an alleged incident of resident to resident abuse that occurred on two days prior to the report being submitted. The After-Hours line was called to report the incident on the date the incident occurred.

The document titled “Clarification of Mandatory and Critical Incident Reporting Requirements” amended August 31, 2018, indicated that a CIS form was required to be submitted the following business day. The CIS report should have submitted the following business day and it was not.

Sources: "Clarification of Mandatory and Critical Incident Reporting Requirements" amended August 31, 2018; CIS report; interview with the DOC. [s. 104. (2)]

Issued on this 11th day of March, 2021

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

Original report signed by the inspector.