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
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159, rue Cedar Bureau 403
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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
Mar 31, 2021	2021_824736_0006	002181-21, 004542-21	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

AMANDA BELANGER (736)

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 15-19, 2021.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:
-two logs related to reports submitted to the Director for an allegation of improper or incompetent care of residents.

A Follow Up Inspection #2021_824736_0005 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance of a Compliance Order (CO) related to s. 36 of the Ontario Regulations 79/10, and non-compliance of a Voluntary Plan of Correction (VPC) related to s. 6 (9) of the LTCHA 2007, were identified in this inspection and have been issued in Inspection Report, #2021_824736_0005, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Associate Director of Nursing (ADON), acting Associate Director of Nursing (acting ADON), the Infection Prevention and Control lead, Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), and an Occupational Therapist from West Parry Sound Health Centre (WPSHC).

The Inspector also conducted a tour of resident care areas, reviewed relevant health care records, licensee policies, audits and educational records, and observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 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.

a) During the inspection, the Inspector observed a Personal Support Worker (PSW) at the nursing station, without goggles or a face shield. There was a resident within two metres of the PSW. The PSW then entered a resident room twice to provide assistance without goggles or a face shield.

In an interview with the PSW, they indicated to the Inspector that staff were required to utilize a mask and eye protection as Personal Protective Equipment (PPE) at all times while in the home and while providing care to residents. The PSW confirmed that they did not have the appropriate PPE in place.

Sources: Inspector's observations; interview with PSW, and other staff; licensee policy titled "Personal Protective Equipment", last reviewed January 22, 2021.

b) During the inspection, the Inspector also observed a staff member enter a resident room. The Inspector noted that there was PPE located on the resident's door, however no signage. The staff member exited the resident's room, and was not wearing a gown or gloves.

A review of the resident's progress notes, indicated that the resident required additional infection control precautions.

In an interview with the IPAC lead for the home, they indicated that when staff were entering a resident's room, who required additional infection control precautions, the staff were to utilize appropriate PPE. The IPAC lead indicated that it was the expectation of the home that staff use the appropriate PPE, including a gown and gloves.

Sources: Inspector observations; the resident's progress notes; interview with IPAC lead, as well as other staff; licensee's policy titled "Additional Precautions", last reviewed January 13, 2021.

c) Lastly, during the inspection, the Inspector noted a staff member enter a resident's room, and assist the resident with their activities of daily living (ADLs). The staff member then exited the resident's room, and prepared a snack and drink from the snack cart; without performing hand hygiene.

The same staff member was then observed putting on a pair of gloves, although no hand hygiene was observed by the Inspector.

In an interview with the IPAC lead for the home, they indicated that staff were to complete hand hygiene after an interaction with a resident, and after leaving the resident's environment, as well as prior to preparing a snack, and prior to putting on gloves. The IPAC lead indicated that if moments of hand hygiene were missed, staff were not participating in the IPAC program.

Sources: Inspector observations; interview with IPAC lead, as well as other staff; licensee policy titled "Hand Hygiene", last reviewed December 11, 2020. [s. 229. (4)]

2. 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 indicated that the resident was on additional precautions to prevent transmission of infection.

During the inspection, the Inspector noted two resident room's with PPE supplies outside the doors with no signage posted indicating that specific additional precautions were required. The PSW indicated to the Inspector that one resident required additional IPAC precautions. Another PSW indicated to the Inspector that the second resident also required additional IPAC precautions.

As per the home's policy, appropriate IPAC signage should have been posted, to ensure proper use of PPE to protect staff and other residents in the home from the 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 January 13, 2021; two residents'; and interviews with the IPAC Lead and other staff. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. The licensee has failed to ensure that care was provided to two residents, related to toileting, as set out in their plans of care.

a) Resident #001's care plan provided direction to staff related to toileting.

During an internal investigation, it was discovered that staff were not following the interventions in the resident's care plan for toileting; instead, toileting the resident in a different way that was not part of the resident's plan of care.

In an interview with the Director of Nursing (DON), they indicated that staff should have provided care to resident #001 as per their plan of care; and the staff were not providing care as per the resident's plan of care.

Sources: Resident #001's care plan; internal investigation notes; Critical Incident (CI) report; interview with DON, and other staff.

b) Resident #002's care plan provided direction to staff related to toileting.

During an audit of lifts and transfers, it was noted that staff were not toileting the resident the way that the care plan had indicated.

In an interview with the DON, they indicated that staff should have provided care to resident #002 as per their plan of care; and that as staff were not toileting the resident as specified in the care plan, the staff were not providing care as per the resident's plan of care.

Sources: Resident #002's care plan; internal investigation notes; CI report; interview with DON, and other staff. [s. 6. (7)]

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 care is provided to residents as per their plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Findings/Faits saillants :

1. The licensee has failed to ensure that a staff member complied with the home's zero tolerance of abuse policy, related to immediately reporting the improper or incompetent care of the resident.

The DON received an email from the physiotherapist, indicating that the physiotherapist had witnessed staff members using improper equipment for the resident.

In an interview with the DON, they indicated that the e-mail was an allegation of incompetent care for the resident, and that the physiotherapist should have immediately brought the concerns forward. The DON indicated that as the physiotherapist had not brought the concerns forward immediately, the home's zero tolerance of abuse policy had not been complied with.

Sources: CI report; internal investigation package; interviews with the DON; licensee policy titled Abuse-investigation. [s. 20.]

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 comply with the home's zero tolerance of abuse policy, to be implemented voluntarily.

Issued on this 12th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA BELANGER (736)
Inspection No. / No de l'inspection :	2021_824736_0006
Log No. / No de registre :	002181-21, 004542-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 31, 2021
Licensee / Titulaire de permis :	Lakeland Long Term Care Services Corporation 6 Albert Street, Parry Sound, ON, P2A-3A4
LTC Home / Foyer de SLD :	Lakeland Long Term Care Services 6 Albert Street, Parry Sound, ON, P2A-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve White

To Lakeland Long Term Care Services Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of the Ontario Regulation 79/10.

The licensee shall ensure that that all staff participate in the implementation of the Infection Prevention and Control Program (IPAC); specifically, the appropriate usage of Personal Protective Equipment (PPE), and hand hygiene, as well as ensuring appropriate signage is posted in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

a) During the inspection, the Inspector observed a Personal Support Worker (PSW) at the nursing station, without goggles or a face shield. There was a resident within two metres of the PSW. The PSW then entered a resident room twice to provide assistance without goggles or a face shield.

In an interview with the PSW, they indicated to the Inspector that staff were required to utilize a mask and eye protection as Personal Protective Equipment (PPE) at all times while in the home and while providing care to residents. The PSW confirmed that they did not have the appropriate PPE in place.

Sources: Inspector's observations; interview with PSW, and other staff; licensee policy titled "Personal Protective Equipment", last reviewed January 22, 2021.

b) During the inspection, the Inspector also observed a staff member enter a resident room. The Inspector noted that there was PPE located on the resident's door, however no signage. The staff member exited the resident's room, and was not wearing a gown or gloves.

A review of the resident's progress notes, indicated that the resident required additional infection control precautions.

In an interview with the IPAC lead for the home, they indicated that when staff were entering a resident's room, who required additional infection control precautions, the staff were to utilize appropriate PPE. The IPAC lead indicated that it was the expectation of the home that staff use the appropriate PPE, including a gown and gloves.

Sources: Inspector observations; the resident's progress notes; interview with IPAC lead, as well as other staff; licensee's policy titled "Additional Precautions", last reviewed January 13, 2021.

c) Lastly, during the inspection, the Inspector noted a staff member enter a resident's room, and assist the resident with their activities of daily living (ADLs). The staff member then exited the resident's room, and prepared a snack and drink from the snack cart; without performing hand hygiene.

The same staff member was then observed putting on a pair of gloves, although no hand hygiene was observed by the Inspector.

In an interview with the IPAC lead for the home, they indicated that staff were to complete hand hygiene after an interaction with a resident, and the resident's environment, as well as prior to preparing a snack, and prior to putting on gloves. The IPAC lead indicated that if moments of hand hygiene were missed, staff were not participating in the IPAC program.

Sources: Inspector observations; interview with IPAC lead, as well as other staff; licensee policy titled "Hand Hygiene", last reviewed December 11, 2020. (736)

2. 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 indicated that the resident was on additional precautions to prevent transmission of infection.

During the inspection, the Inspector noted two resident room's with PPE

supplies outside the doors with no signage posted indicating that specific additional precautions were required. The PSW indicated to the Inspector that one resident required additional IPAC precautions. Another PSW indicated to the Inspector that the second resident also required additional IPAC precautions.

As per the home's policy, appropriate IPAC signage should have been posted, to ensure proper use of PPE to protect staff and other residents in the home from the 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 January 13, 2021; two residents'; and interviews with the IPAC Lead and other staff.

An order was made by taking the following factors into account:

Severity: Actual risk was identified in the home related to risk of disease transmission.

Scope: The scope of this non-compliance was widespread because of the identified concerns in all home areas, related to IPAC and hand hygiene.

Compliance History: One Voluntary Plans of Correction (VPCs) related to this subsection, as well as eight Compliance Orders (COs), nine VPCs and five Written Notifications (WNs) were issued to the home related to different sub-sections of the legislation in the past 36 months.
(736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Belanger

Service Area Office /
Bureau régional de services : Sudbury Service Area Office