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

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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
Jan 4, 2022	2021_907692_0011	014484-21, 017178-21, 017371-21	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

SHANNON RUSSELL (692)

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): December 6-10, 2021.

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

-One intake, related to an unexpected death of a resident; and

-Two intakes, related to allegations of staff to resident physical abuse.

Follow Up inspection #2021_907692_0010 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Nursing (IDON), Acting Assistant Director of Nursing (A/ADON), Infection Prevention and Control (IPAC) Resource Nurse, Housekeepers, Nurse Managers (NMs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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

PLEASE NOTE: Non-compliance related to s. 24 (1) of the Long-Term Care Homes Act (LTCHA), 2007, was identified in this inspection and has been issued in Follow Up Inspection report #2021_907692_0010, which was conducted concurrently with this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by Personal Support Worker (PSW).

Physical abuse is defined within the Ontario Regulations (O. Reg) 79/10 of the Long Term-Care Homes Act (LTCHA), 2007, as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A resident had sustained an injury, which a PSW reported to a Registered Practical Nurse (RPN) that the injury was not present prior to care being provided by another PSW. The resident had indicated to staff that the injury had been caused by a specific PSW when they were assisting the resident with their care. Three days later, the resident also told staff that they did not want that PSW to provide care for them. These incidents were not reported to the Director of Nursing (DON) until four days after the initial incident; and the PSW had continued to work in the home.

The Acting Assistant Director of Nursing (A/ADON), identified that the allegation of physical abuse towards the resident had been founded, as the PSW had used excessive force when providing care.

Sources: Critical Incident System (CIS) report; the home’s policy, “ADM-RF Abuse Investigation”, last updated June 2021; a resident's health care records; internal investigation notes; interviews with direct care staff, and the A/ADON. [s. 19. (1)]

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 residents are protected from abuse by anyone, 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, specifically to ensure there was signage posted on or near the room entrance of affected residents that indicated the resident was on additional precautions.

In accordance with Public Health Ontario (PHO), Routine Practices and Additional Precautions in All Health Care Settings, homes were required to have signage specific to the type(s) of additional precautions posted. A sign that lists the required precautions was to be posted at the entrance to the resident's room or bed space.

On two consecutive days, the Inspector observed two resident rooms that had a caddy with Personal Protective Equipment (PPE) present outside the room and a doffing station; however, the Inspector could not locate signage to identify the type of isolation precautions required for either of these residents. Direct care staff interviewed at the time, identified that both residents had been placed on additional precautions and that there should have been signs placed on their doorways to alert those entering the room that additional precautions were required.

During an interview with the IPAC Resource Nurse, they identified that with no signage in place the proper precautions would not be followed, which would increase the risk of spreading infection to other residents.

Sources: Inspector's observations; record reviews including diagnosis, care plan and progress notes for two residents; PHO, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012; the licensee's policy titled, "Additional Precautions", last revised December 2020; interviews with direct care staff, and the IPAC Resource Nurse. [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 staff participate in the implementation of the infection prevention and control (IPAC) program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision maker (SDM) was notified immediately of an allegation of abuse causing injury.

A PSW reported to a RPN that a resident had an injury that had not been present prior them being provided care by a specific PSW. Progress notes for the resident indicated that their SDM was not notified of the resident’s injury until three days after the alleged incident.

The A/ADON identified that the resident’s SDM was to have been notified of any change in the resident status, and they should have been notified immediately of the injury and the allegation of abuse towards the resident, and that they had not been notified until three days after the injury was reported to registered staff.

Sources: CIS report; a resident’s health care records; internal investigation notes; licensee policy titled, “ADM-OP Reporting Process for Critical Incidents”, last reviewed December 18, 2020; interviews with direct care staff and the A/ADON. [s. 97. (1) (a)]

Issued on this 14th day of January, 2022

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

Original report signed by the inspector.