Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

North District
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Original Public Report

Report Issue Date: March 28, 2024	
Inspection Number: 2024-1441-0001	
Inspection Type: Critical Incident	
Licensee: Lakeland Long Term Care Services Corporation	
Long Term Care Home and City: Lakeland Long Term Care Services, Parry Sound	
Lead Inspector Charlotte Scott (000695)	**Inspector Digital Signature**
Additional Inspector(s) Parimah Oormazdi (741672)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26-29, 2024
The inspection occurred offsite on the following date(s): February 28, 2024

The following intake(s) were inspected:

- One intake related to alleged improper/incompetent care of a resident by staff;
- One intake related to alleged verbal abuse and improper/incompetent care of a resident by staff; and,
- One intake related to an outbreak of Covid-19.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee did not ensure the hand hygiene program included alcohol-based hand rub (ABHR) with an alcohol content of 70-90% as required under the IPAC Standard issued April 2022, last revised September 2023.

Rationale and Summary
During the course of the inspection, the Inspector observed hand-pump ABHR

throughout the home with an alcohol content of 60%. The Inspector observed staff offering residents the 60% ABHR at the time of meal service.

Multiple staff indicated that the hand-pump ABHR was commonly used to offer hand hygiene to residents, and confirmed the product contained 60% alcohol. The IPAC Lead acknowledged that while they were not aware the product only contained 60% alcohol content, the ABHR did not meet the requirement of 70-90%.

During the inspection, the IPAC Lead indicated all of the hand-pump ABHR in the home had been replaced with another product that contained 70% alcohol content and indicated a memo had been sent out to all staff in addition to the home's supply order being updated to the new product. Inspector observations confirmed the product had been replaced throughout the home.

There was low risk to residents when the home failed to ensure ABHR used in the home contained 70-90% alcohol content as required by the IPAC Standard.

Sources: Inspector observations, IPAC Standard for Long-Term Care Homes (effective April 2022, revised September 2023), a memo issued by the home titled "IsaGel Hand Pump Sanitizer", an email titled "Updated Meditech number for hand sanitizer gel", and interviews with the IPAC Lead and other staff.
[000695]

Date Remedy Implemented: February 28, 2024

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff followed safe transferring techniques when an identified staff member did not transfer a specific resident in the manner required.

Rationale and Summary
The identified staff member transferred the resident using a specific method independently. At the time of the incident, the resident's care plan indicated that when using the specific method, two staff were required.

The Director of Nursing (DON) stated that the expectation of the home was to transfer the resident with two staff assistance as per their care plan.

Failure to follow safe transferring techniques for the resident put the resident at risk of injury.

Sources: The Critical Incident (CI) report, the resident's clinical notes, interview with the identified staff member and the DON.
[741672]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights

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 inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality, regardless of their health condition.

Rationale and summary
Following an alleged incident of abuse of the resident by a staff member, the home conducted an investigation and identified that the staff had violated the resident's bill of rights.

The DON stated that the resident should have been respected in any circumstances and that the staff member's behaviour was not acceptable.

Failure to respect the resident resulted in not following the resident's bill of rights and put the resident at risk of being emotionally distressed.

Sources: The CI report, home's investigation notes, the resident's clinical notes, interviews with the DON and other staff.
[741672]