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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2013	2013_140158_0035	S-000005	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 CORPORATION
6 ALBERT STREET, PARRY SOUND, ON, P2A-3A4

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

KELLY-JEAN SCHIENBEIN (158)

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): September 9, 10, 2013

The Inspector conducted the inspection in both the ELDCAP unit (Facility # 2966) and the Long Term Care unit (Facility #2958.)

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Clinical Coordinator, Registered staff, Personal Support Workers (PSW) and some residents.

During the course of the inspection, the inspector(s) conducted a walk-through of 2 resident areas and various common rooms, observed the care of residents, observed staff to resident interactions, reviewed various policies and procedures and some residents' health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

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1. Resident # 03 fell four times in August 2013 and sustained injuries during two of the falls.
The Inspector observed that two staff assisted with the transfer of resident # 03 on September 10, 2013.
On September 10, 2013, the Inspector reviewed resident # 03 flow sheets (September 9-15/13), which identified that 2 staff assisted the resident with transferring from bed to chair on September 9-10, 2013. Resident # 03 plan of care, however, does not identify that the assistance of 2 staff is required for transfers. Staff # S-100 identified to the Inspector that resident # 03 is now a 2-person pivot related to her numerous falls.
The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to resident # 03. [s. 6. (1) (c)]

2. Resident # 03 fell four times in August 2013, with one fall resulting in an injury, which required treatment at the hospital.
The Inspector reviewed resident # 03 health care records on September 10, 2013. It was documented on the post fall assessment that resident # 03, who has poor trunk control was left unattended on the toilet and sustained an injury requiring transfer to hospital after falling off the toilet.
Resident # 03 plan of care identified that resident # 03 was not to be left unattended on the toilet.
The licensee did not ensure that the care set out in the plan of care was not provided to resident # 03 as specified in the plan [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 ensuring that care set out in the plan of care is provided to resident # 03 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Resident # 03, who fell in August 2013, sustained an injury which required treatment at the hospital. This injury, which required transfer to the hospital was not reported to the Director. The licensee failed to report to the Director, an injury in respect of which the person is taken to hospital in one business day after the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 18th day of November, 2013

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