Ontario

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
Sep 6, 2013	2013_159178_0017	T-334-13	Complaint

Licensee/Titulaire de permis

University Health Network
550 UNIVERSITY AVENUE, TORONTO, ON, M5G-2A2

Long-Term Care Home/Foyer de soins de longue durée

LAKESIDE LONG TERM CARE CENTRE
150 DUNN AVENUE, TORONTO, ON, M6K-2R6

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 31, August 1, 2, 6, 2013.

During the course of the inspection, the inspector(s) spoke with Executive Director, Nurse Consultant, Social Worker, registered staff, personal support workers, private companion, family of resident.

During the course of the inspection, the inspector(s) observed resident care, reviewed resident records, reviewed home records and policies.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

Responsive Behaviours

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.) 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.
Staff interviews, family interviews and record review confirm that the substitute decision maker (SDM) for Resident # 1 was not consulted or informed when the resident was started on a new medication in February 2013. The resident's SDM was informed by hospital staff that the resident had been receiving the identified medication, when the resident was later admitted to hospital for an unrelated condition. [s. 6. (5)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at any time when the resident's care needs change.
Due to a delay in specimen collection, Resident # 1 was not reassessed and the plan of care was not revised for more than 12 days after the resident showed signs of possible infection in September 2012.

Record review, staff and family interviews confirm the following:
-Resident # 1 has a history of urinary tract infections, which can increase his/her agitation.
-during September 2012, Resident # 1 was experiencing diarrhea, as well as confusion, agitation and responsive behaviours.
-a physician's order was written for Resident # 1 on September 18, 2012 ordering that a urine specimen be collected using the clean catch method, and sent for culture and sensitivity (C & S) and routine microbiology (R & M). On the same date an order was written for a stool specimen to be collected and sent to be tested for C & S, and for Clostridium Difficile (C. Diff) toxin.
-the urine specimen was collected 12 days later on October 1, 2012, and showed evidence of a urinary tract infection (UTI) for which the resident was provided antibiotic treatment.
-the stool for C. Diff was collected 30 days later on October 18, 2012, and the stool for C & S was collected 36 days later on October 24, 2012. Both stool specimen tests were negative.
-the delay in specimen collection caused a delay in assessment of the resident's UTI, which resulted in delayed treatment of the resident's UTI.
-Record review and staff interviews confirm that Resident # 1 can be resistive to care, which can delay collection of a urine or stool specimen. However, progress notes indicate several instances during the delay when the resident was calm and

cooperative, and there is no indication that an attempt was made to collect a specimen at that time. [s. 6. (10) (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 to ensure that:
-residents and their SDMs are given an opportunity to participate fully in the development and implementation of the plan of care, particularly in regards to new medications or treatments
-all residents are reassessed and their plans of care reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

Family interviews, staff interviews and record review confirm that on October 5, 2012, Resident # 1 was not administered drugs as specified by the prescriber.
On October 5, 2012, Resident # 1 refused to take his/her 1600h medications, and as a result the medications were wasted. At 1730h when the resident had family present and was calmer, the registered staff member administered the resident's medications which were ordered for 2000h. These medications were the same as the 1600h medications, but at a higher and more sedating dose than the 1600h dose which had been refused earlier.
As a result, the resident became very drowsy during the evening. [s. 131. (2)]

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 drugs are administered to the residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home have been immediately forwarded to the Director under the Long Term Care Homes Act (LTCHA).
Staff interviews, family interviews and record review confirm that between April 22, 2012 and May 24, 2013 numerous written complaints were submitted to the home by the SDM of Resident # 1 concerning the resident's care. Staff interviews confirm that none of these written complaints were forwarded to the Director under the LTCHA. [s. 22. (1)]

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Issued on this 9th day of September, 2013

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

Susan Lin (178)