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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 19, 2015	2015_440210_0012	0027973-15	Resident Quality Inspection

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

SLAVICA VUCKO (210), ARIEL JONES (566), JUDITH HART (513), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 15, 16, 19, 20, 22, 23, 26, 27 and 28, 2015.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW)), Registered Dietitian (RD), Dietary Aide (DA), Infection Control Nurse, Social Worker (SW), Maintenance Director, Private Care Givers, Resident Programs Manager, Resident Council vice-president, Family Council president, substitute decision makers (SDM), residents, family members of residents, performed a tour of the home, reviewed residents' records and home's policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On October 23, 2015, after the lunch meal, the inspector observed resident #011 in his/her bed with one long bed rail raised on one side and a pillow placed on the other side.

A review of the current written care plan indicated that the resident requires assistance for bed mobility, is unable to move and get out of bed, and that he/she is using one long side rail on one side and one quarter side rail on the other side. The minimum data set (MDS) assessment on an identified date indicated side rails (e.g. half rail, one side) were used less than daily. The MDS assessments on identified dates indicated the side rails (e.g. half rail, one side) were used daily.

A review of the written plan of care history revealed that a written plan of care was not developed for an identified period between 2014 and 2015, in regards to the use of bed rails.

A review of the written plan of care and interviews with registered staff #107, the RAI Coordinator and the DOC confirmed that resident #011's written plan of care was not developed for an identified period between 2014 and 2015, in order for the plan of care to set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On October 23, 2015, the inspector observed resident #010 in bed on a pressure relief mattress with one long bed rail raised on one side and one half bed rail raised on the other side. Both bed rails had bumper pads applied.

A record review of the written plan of care did not reflect the use of bumper pads until October 26, 2015, during the inspection period.

An interview with PSW #111 revealed that bumper pads had been in place for a period of one year. An interview with registered staff #110 revealed that the bumper pads have been in place for a period of time but could not identify specifically the exact length of time.

An interview with the DOC indicated that the expectation is that the use of bumper pads are to be documented in the written plan of care and confirmed that the same was not identified for resident #010 in order to set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. On October 23, 2015, during the lunch meal service, the inspector observed resident #010 assisted by a staff member drinking regular fluids from a glass and using a specified intervention.

A record review revealed that the resident is at risk for impaired physical functioning associated to his/her medical diagnosis and requires total assistance with eating and drinking.

Interviews with DA #112, PSW #111 and registered staff #110 indicated that the resident is provided a specified intervention for drinking for an unidentified period of time for ease of drinking. Furthermore, the registered staff #110 confirmed that a written plan of care was not in place for resident #010, in regards to the use of a specified intervention.

An interview with the RD revealed awareness of the resident's use of a specified intervention for drinking with no contraindications and confirmed that resident #010's written plan of care did not reflect the use of a specified intervention.

An interview with the DOC indicated that the expectation is for interventions including the use of a specified intervention to be documented in the written plan of care and confirmed that the same was not identified for resident #010 in order to set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

A review of the policy titled "Medication System-Carded System," index number 04-01-20, dated June 23, 2013, identified under item #10, that "all medications for individual residents must be labelled with an expiration date on the original container."

On October 26, 2015, at 2:10 P.M. the inspector observed in a drawer of the medication cart on 1st floor to contain a pill container dispensed on June 10, 2013, by pharmacy for 15 tablets of Trazodone 50 mg, as needed (PRN). There was no expiration date on the label.

An interview with registered staff #117 confirmed that the identified medication was dispensed on June 10, 2013, and did not have an expiration date.

An interview with the DOC confirmed that the pill containers should be labelled by the pharmacy supplier identifying the expiration date, which is one year following the dispensing date. [s. 8. (1) (b)]

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.