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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 22, 2017 | 2017_642606_0020 | 027584-17 | 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

JANET GROUX (606), SARAH KENNEDY (605)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): December 5, 6, 7, 8, and 11, 2017.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Infection Control (IC) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), president of the Residents' Council, Substitute Decision Makers (SDM), and Residents,**

**During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed a resident medication administration, observed infection control staff practices, interviewed the Residents' Council (RC) president, completed a survey with the Family Council (FC) president, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Safe and Secure Home**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure all doors leading to non-residential areas are locked when they are not being supervised by staff.

During the initial tour of the home on December 5, 2017, the following observations were noted:

a) On an identified floor, the clean utility room was unlocked. The room contained identified resident personal care items. RPN #107 confirmed the door was unlocked and took action to lock the door. In addition, both the doors leading to the men and women's locker rooms were unlocked. The locker rooms do not contain call bells.

b) On an identified floor, the soiled linen room was found unlocked. The room contains disinfectant and a laundry chute. PSW #109 confirmed the door was unlocked. Maintenance #108 fixed the door and ensured it was locked immediately. Another observation on December 7, 2017, revealed the soiled linen room door was unlocked again.

Observations on December 8, 2017, revealed all of the identified doors were locked.

An interview with the Administrator confirmed the expectation is for all doors leading to non-residential areas to be kept locked. The Administrator stated that both the locks on the soiled utility room on an identified floor and the women's locker room were replaced as they were not working properly. [s. 9. (1) 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 all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.***

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**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 all staff participate in the implementation of the program.

The inspector observed on December 7, 2017, at 1120hrs RPN #103 did not perform hand hygiene before and after he/she administered medications to residents #014, #015, and #016.

Interview with RPN #103 indicated that the home's practice is to always perform hand hygiene before and after resident care and that there is always a hand sanitizer located on the medication cart but forgot to use it today during the medication administration.

Interviews with RPN #104, the Infection Control Lead, and the DOC indicated staff must perform hand hygiene before and after resident care to prevent the spread of infections. [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 all staff participate in the implementation of the program, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

The inspector observed on December 7, 2017, at 1230 hours (hrs) on an identified floor, a medication cart located in front of the nursing station counter with e-Mar (electronic medication administration record) monitor screen left on and unattended with resident #017's personal health information visible for others nearby.

Interview with RPN #103 indicated that he/she forgot to close the monitor but the practice was to always turn off the screen when walking away from the medication cart.

Interviews with the DOC and RPN #104 indicated registered staff must close the screen when the e-Mar is left unattended. [s. 3. (1) 11. iv.]

**Issued on this 2nd day of January, 2018**

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

**Original report signed by the inspector.**