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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2018	2018_634513_0008	015760-18	Resident Quality Inspection

Licensee/Titulaire de permis

University Health Network
R. Fraser Elliott Building 1S-417 190 Elizabeth Street TORONTO ON M5G 2C4

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

JUDITH HART (513), ADAM DICKEY (643), DEREGE GEDA (645)

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): July 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, and 18, 2018.

Log #012620-18 for CIS #2929-000003-18, related to a medication incident, was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Registered Dietitian, Residents' and Family Council Presidents, Social Worker, MDS/RAI Coordinator, maintenance personnel, residents and family members.

During the course of the inspection, the inspectors conducted observations in home and resident areas, observations of care delivery processes including medication administration, meal delivery services and reviewed residents' health records and policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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 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 where the act or 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 was required to ensure that the plan, policy, protocol, procedures strategy or system was complied with.

A) The home submitted a Critical Incident Report (CIR) #2929-000003-18, on a specified date. Four vials of medication were found in the dispensing box broken and empty.

A review of the home's policy titled, Narcotic and Controlled Substances Administration Record, dated January 17, 2017, stated, any discrepancies must be reported to the Director of Nursing/Care or Resident Service Manager as soon as they are discovered.

A review of the home's Medication Incident Report #MIR-10060, on a specified date, stated when Registered Nurse (RN) #116 was cleaning the medication cart, they heard noise in the medication box and found four broken ampules of medication.

A review of the investigation notes related to this incident indicated four ampules of medication were found broken in their container packaging by RN #116 during a specified shift and date.

An interview with RN #116, who worked the specified shift on the aforementioned date, stated, during the cleaning of the medication cart when the box of medication was retrieved from the secured location for a specific resident, a clicking, broken glass sound

could be heard coming from the box. The interior of the box was examined and two trays holding the medication were observed: one tray held 5 intact ampules and the second tray held four broken ampules; all pieces appeared to be in the tray. The management of the home, including the DOC were not immediately notified of the breakage. The RN who worked a specified shift was to endorse the finding to the next shift, who would then notify the Director of Care (DOC).

An interview with oncoming RN #117, who worked a specified shift on the aforementioned date, stated, four ampules were observed to be broken at the end of the shift during the medication count with outgoing RN #116, which was reported to be discovered by RN #116 as previously noted. The management of the home, including the DOC were not notified of the breakage as soon as they were discovered.

An interview with oncoming RPN #118, during the medication count on a second specified date and time stated they counted the medications with outgoing RN #117. Four broken vials of medication, with what appeared to be all shards, tops and bottoms of the ampules observed in the packaging and this was reported to the DOC.

An interview with the DOC stated that RN #116 and RN #117 did not notify management or the DOC regarding the four broken medication ampules, when the discrepancy with the medication count was identified. The DOC confirmed the policy for reporting such medication count discrepancies was not followed.

B) A review of home's policy titled, Narcotic and Controlled Substances Administration Record, dated January 17, 2017, stated, a check of the balance-on-hand must be done by two nurses or care providers as per facility policy at the time of every shift change.

The home's investigation documents on a specified date indicated that RN #128 was interviewed by the Executive Director (ED) and DOC. RN #128 stated they completed the controlled substances count independently.

On July 17 and 18, 2018, RN #128 was not available for an interview as they could not be reached by phone.

The home's investigation records on a specified date, by the DOC with RN #128 stated, while working a specific shift and date, RN #128 did not count the controlled substances with outgoing RN #121.

The home's interview transcript on a specified date, by the ED with RN #128 further stated that RN #128 worked the previously identified shift and date, completed the controlled substances count independently and confirmed RN #128 did not follow the home's policy when completing the medication count. [s. 8. (1) (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 where the Act or 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, procedures strategy or system was complied with, to be implemented voluntarily.

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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During stage two of the Resident Quality Inspection (RQI) a specific resident triggered for a specified condition during stage 1 of the RQI.

A review of the Minimum Data Set (MDS) for a specified date indicated the resident had a medical condition.

A review of the progress notes identified the resident was treated with a medication.

A review of the progress notes, vital sign records and 24hour reports on specified dates was completed. On three specified dates and shifts, no vital signs were found to be recorded:

On two identified dates, no progress notes were found for one of the shifts.

An interview with RN #124 identified vital signs would be recorded as part of the monitoring for a specific medical condition and confirmed no recording of vital signs and progress notes were found for the previously noted dates and shifts.

An interview with the DOC identified the expectation of the home for a resident with a specified medical condition would be for the resident to be put on precautionary measures, the family notified, staff would monitor the resident and assess the resident's overall status, intake, vital signs and overall well being each shift. The DOC confirmed the monitoring of symptoms of the specified condition, including vital signs and progress notes on the aforementioned dates and shifts were not documented, therefore, symptoms of the specified condition were not monitored on every shift. [s. 229. (5) (a)]

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 staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #3: 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. (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 the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage two of the RQI resident #007 was triggered for a specific area of inspection from a staff interview during stage one.

A review of resident #007's health records indicated they had a recent measurement of height and weight. A review of the resident's specified measurements over a specified period of time indicated they remained in a stable range.

A review of the resident's progress notes showed a referral was submitted to the Registered Dietitian (RD) on a specified date, related to a recent decline in intake. The RD assessed resident's nutritional status and ordered nutritional supplementation. A subsequent referral was submitted to the RD on a second specified date, indicating poor

intake of the supplementation. The progress note by the RD on a specified date indicated the resident enjoyed a specified food intervention at a specific meal.

A review of the resident's written plan of care indicated the resident was to be provided a specific intervention at a specific meal, initiated on a specified date. Observation of the resident's meal service on a specified date showed the resident was not offered the specific intervention, but ate 75 percent (%) to 100% of the entrée.

In interviews, PSW #108 and RPN #110 indicated the resident had been receiving a specific intervention a few months previous. PSW #108 and RPN #110 indicated the resident's intake had improved and was only being provided with the specific intervention if they did not eat the entrée provided. RPN #110 indicated the resident's care plan would be updated when the resident's care needs changed or interventions were no longer necessary, but it had not been updated.

An interview with RD #111 indicated receiving a nutrition referral regarding resident #007's intake and had introduced the specific intervention after other interventions were not effective. The RD indicated staff had not communicated the change in the resident's needs and they were only providing the specific intervention previously noted if the entrée was not taken. The RD indicated the care plan would be updated when the resident's care needs changed and later updated the care plan to reflect the change in the resident's needs.

An interview with the DOC indicated the expectation of the home was that resident care plans would be reviewed and revised on a quarterly basis and whenever a resident had a change in condition. The DOC stated the plan of care was a living document and would need to be updated on an ongoing basis when needs of the resident changed. The DOC acknowledged that for this resident, the licensee had failed to ensure that the resident was reassessed and the plan of care reviewed and revised when their care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Minutes dated June 19, 2017, identified four questions raised by the Family Council.

A review of the home's Family Council form titled, Lakeside Long Term Care-Topics of Concern that were Raised at the Family Council Meeting, dated June 27, 2017, identified a response by the ED for each concern identified during the meeting of June 19, 2017. The date of signature of the Family Council Chair receiving the home's response was dated August 21, 2017.

An interview with the Family Council Chair stated the home responds within 10 days to concerns, however regarding the response for the concerns identified in the June 19, 2017, Family Council meeting, the Chair was not able to find any email or other communication from the home to the Family Council to confirm receiving the home's response prior to August 21, 2017.

An interview with the Family Council Assistant stated, no email documentation from the desk of the ED was found to indicate communication with the chair within the 10 days of receiving the Family Council concerns.

An interview with the ED confirmed unsureness of the date the Family Council President was informed. The ED noted that the date of the Chair's signature on the above noted response form was August 21, 2017, indicating receipt of the report, therefore, not ensuring a response from the licensee was received by the Family Council within 10 days. [s. 60. (2)]

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Issued on this 3rd day of August, 2018

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

Original report signed by the inspector.