Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: December 30, 2022	
Inspection Number: 2022-1413-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: University Health Network	
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto	
Lead Inspector Nira Khemraj (741716)	**Inspector Digital Signature** Niranjani Khemraj Digitally signed by Niranjani Khemraj Date: 2022.12.30 14:55:09 -05'00'
Additional Inspector(s) Slavica Vucko (210)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

November 16, 18, 21, 22, 23, 28, 29 and 30, 2022.

The following intake(s) were inspected:

Intake: #00001789 - Critical Incident System (CIS) report related to injury of resident with unknown etiology.
Intake: #00003092 - CIS related to fall of resident resulting in injury and hospitalization.
Intake: #00004738 - CIS related to improper transfer of resident resulting in injury.
Intake: #00011874 - Complaint pertaining to hospitalization and multiple injuries of unknown cause.
Intake: #00012283 - Complaint related to injury with unknown etiology.
Intake: #00012774 - Complaint related to personal care and services.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Reporting and Complaints

Falls Prevention and Management
Infection Prevention and Control
Staffing, Training and Care Standards
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 249 (3) (d)

The licensee has failed to ensure that the home's Administrator who was recently hired has successfully completed or was enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

Rationale and Summary
During the course of the inspection the Administrator of the home was not enrolled in a program in long-term care home administration or management.

On November 30, 2022, the Administrator presented that they were enrolled in an eligible program that was at least 100 hours long.

Sources: review of the Administrator's education program in long-term care administration and interview with staff.

Date Remedy Implemented: November 30, 2022.

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WRITTEN NOTIFICATION: Dignity and Respect

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1)

The licensee has failed to ensure that every residents' right to be treated with courtesy and respect related to pleasurable dining was fully respected and promoted for resident #009.

Rationale and Summary
A complaint was lodged alleging resident #009 was fed a meal in an inappropriate location. As per the residents' plan of care, their preference was to have their meals in a different location. In an interview with PSW #143, they stated they fed the resident a meal in the inappropriate location because they were not able to receive assistance from another staff to bring the resident to their preferred location to have their meal.

Failure for resident #009 to receive their meal in an appropriate location resulted in the resident's right to being treated with courtesy and respect not being fully respected and promoted.

Sources: Review of resident #009's written care plan and interview with staff.
[741716]

WRITTEN NOTIFICATION: Plan of Care

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed ensure that resident #002's substitute decision-maker, and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

Resident #002 was transferred to hospital due to a change in their health status. Resident #002's substitute decision maker (SDM) was contacted when they were transferred to hospital.

The home did not contact the Substitute Decision Maker (SDM) to inform them about the change in the resident's health status prior to their hospitalization.

Not contacting resident's SDM about the resident's health status change led to missed opportunity for the SDM to participate in decision making for the resident's care in the early stages.

Sources: Review of resident #002's clinical record, hospital records, interview with staff and resident #002's SDM.
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WRITTEN NOTIFICATION: Mandatory Reporting to the Director

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was immediately informed of an incident that caused an injury to resident #001 for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary

Resident #001 was transferred to hospital for a health status change that required a treatment, and the Director was not informed.

Resident #001 had a fall and was transferred to hospital for a treatment. The resident sustained another fall and was hospitalized for treatment of the sustained injury. Resident #001's health status change related to their sustained injury was not reported to the Director and CIS report was not amended.

Failure of the home to report to the Director resident #001's incident that led to health status change and hospitalization led to missed opportunity for informing the Director about the short and long-term interventions for fall preventions.

Sources: Review of resident #001's clinical record, hospital records, interviews with staff.
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WRITTEN NOTIFICATION: Transferring and Positioning techniques

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10 s.36

(i) The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #003.

Rationale and Summary

Resident #003 sustained an injury due to unsafe transferring techniques.

As per resident #003's care plan, staff were expected to utilize specific devices and techniques during transfers to reduce the risk of injury during transfers.

In an interview with PSW #135 and PSW #136 it was confirmed that on an identified date, the resident was not provided a proper transfer resulting in the resident sustaining an injury.

Failure the staff to use safe transferring techniques when assisting the resident led to increased risk of injury.

Sources: review of resident #003's written plan of care and interview with staff.
[741716]

(ii) The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #007.

Rationale and Summary
Resident #007 was at risk for injury due to unsafe transferring techniques.

As per resident #007's plan of care staff were expected to use a specific technique for transferring related to the residents' specific health condition. On an identified date, PSW #139 did not perform the transfer as per the plan of care resulting in the resident sustaining an injury.

Failure staff to use safe transferring techniques when assisting the resident led to an increased risk of injury.

Sources: Review of resident #007's written care plan and interview with staff.
[741716]

WRITTEN NOTIFICATION: Absent Residents

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 153 (1)

The license has failed to ensure they maintained contact with a resident who was on a medical absence or with the resident's health care provider in order to determine when the resident will be returning to the home.

Rationale and summary

Resident #002 was transferred to hospital related to a change in their health status. They were diagnosed with unrelated diagnoses and passed away. Resident #002 required advanced level of care for activities of daily living (ADLs). The home did not contact the hospital or the Substitute Decision Maker (SDM) to determine the outcome of the resident's hospitalization, and the cause of death.

Not contacting the hospital and determining the significant change in resident's health condition led to failure the home to initiate an investigation.

Sources: Review of resident #002's clinical record, hospital records, interview with staff and resident #002's SDM.
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