Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: May 23, 2023	
Inspection Number: 2023-1413-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: University Health Network	
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto	
Lead Inspector Ryan Randhawa (741073)	**Inspector Digital Signature**
Additional Inspector(s) Michael Chan (000708) Slavica Vucko (210)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 4-5, 8-12,15, 2023

The inspection occurred offsite on the following date(s): May 17, 2023

The following intake(s) were inspected:
- Intake: #00002538 - [CI: 2929-000025-22] - related to abuse.
- Intake: #00006973 - [AH: IL-97305-AH/CI: 2929-000003-22] - related to medication management
- Intake: #00013997 - 2929-000040-22 - related to improper/incompetent care
- Intake: #00015730 - 2929-000059-22 - related to falls prevention and management.

The following intake(s) were inspected in this Complaints inspection:
- Intake: #00084893, Intake: #00085000 - related to improper care

The following intakes were completed in the CIS inspection:

- Intake: #00005911 - [CI: 2929-000028-22] , Intake: #00004623 - [CI: 2929-000017-22] - related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (1)

The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

Rationale and Summary
A Personal Support Worker (PSW) notified a Registered Practice Nurse (RPN) regarding a resident's change in condition and was sent out to the hospital shortly after. The hospital's diagnostic testing report determined that the resident had a substance in their system related to a medication that was not prescribed to them and was likely from a medication error.

The home's Critical Incident System (CIS) report determined through its internal investigation that the resident was administered a medication that was intended for another resident. The home also found that a Registered Nurse (RN) did not follow medication administration best practices as outlined by the College of Nurses of Ontario (CNO) and the home's policies and procedures.

Interview with the Director of Care (DOC) confirmed that the resident's change in condition was the reason the resident was sent to the hospital and that it was likely caused by the medication administered to them while in the home.

There was harm to the resident when they were administered a medication they were not prescribed which required hospitalization and treatment.

Sources: The long term care home's (LTCH) investigation notes, the resident's clinical records and hospital notes, Extendicare Medication Management Policy (Last revised January 2022), interviews with the DOC and other staff.
[000708]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident was found by staff with an injury from unknown cause and was sent to the hospital for a treatment.

The resident required a level of care from the staff with their activities of daily living (ADL).

The resident was not provided with their correct level of assistance from the staff.

Failure to ensure that the care set out in the plan of care was provided to the resident as specified in the plan lead to unsafe care.

Sources: Review of the resident's written plan of care, home's investigation notes, interviews with the Physiotherapist, a RPN and other staff.
[210]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that, for a resident who demonstrated responsive behaviours, strategies were implemented to respond to these behaviours.

Summary and Rationale

A resident was noted to have an injury for which the cause was unknown. On a later date, the resident sustained a different injury for which the cause was unknown.

The resident displayed responsive behaviour on the days the injuries were noted.

The resident's care plan at the time of the incidents included responsive behaviour strategies to manage the resident's behaviours.

In a period of one month, there were multiple days in which a responsive behaviour strategy was not provided to the resident from the staff.

The Senior Director of Care (DOC) acknowledged that staff failed to implement responsive behaviour strategies to manage the resident's behaviour, as developed in the resident's plan of care.

There was risk of escalation of responsive behaviours and risk of injury to the resident when the resident's behaviour strategies that were developed in their plan of care were not implemented by staff.

Sources: The resident's care plan; the resident's clinical records; and interview with senior DOC and other staff.
[741073]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 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 a fall that caused an injury to a resident for which the resident was

taken to the hospital and resulted in a significant change in their health condition was reported to the Director no later than one business day.

Rationale and Summary

A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) on a specific date for a fall that occurred three days prior in which a resident sustained an injury from a fall and resulted in a significant change in their health status.

The resident fell and was transferred to the hospital. The next day the resident was diagnosed with an injury due to the fall, which the LTCH was aware of.

The Senior Administrator acknowledged that the critical incident should have been submitted to the Director once the injury was confirmed.

Sources: CI Report #2929-000059-22; the resident's clinical records; and interviews with Senior Administrator and other staff.
[741073]