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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 25, 2024
Inspection Number: 2024-1413-0002
Inspection Type: Critical Incident Follow up
Licensee: University Health Network
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Chinonye Nwankpa (000715)	Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2024.05.22 16:19:30 -04'00'

Additional Inspector(s)
Kehinde Sangill (741670)
Vinitaa Rajasingaam (000855) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-4, 8-10, 12, 2024, and April 15, 2024, as an off-site inspection

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00105825 – CI #2929-000006-24 was related to infection prevention and control
- Intake: #00107733 – CI #2929-000010-24 was related to alleged resident to resident abuse

- Intake: #00108291 – CI #2929-000013-24 was related to alleged staff to resident abuse.

The following Follow Up intake(s) were inspected:

- Intake: #00107379 – Compliance Order (CO) #001 related to Infection Prevention and Control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1413-0001 related to O. Reg. 246/22, s. 102 (8) inspected by Kehinde Sangill (741670)

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity.

Rationale and Summary
A resident who required assistance for a shower did not receive the care at the time or their choice. The resident expressed that they were not given the same courtesy and level of care as other residents.

A Registered Practical Nurse (RPN) confirmed that the resident was distressed and required emotional support because of the incident.

Failure to ensure the resident was treated with respect and dignity resulted in emotional distress.

Sources: Critical Incident System, resident's clinical records, home's investigation notes; and interviews with the resident and RPN. [741670]

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)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary
1) A resident did not have a falls prevention device applied as part of their fall management interventions.

A Personal Support Worker (PSW) indicated that they failed to apply the fall prevention device on the resident. The Director of Care (DOC) acknowledged that the falls prevention device was not applied as specified in the resident's care plan.

Failing to apply the resident's fall prevention device increased their risks of fall-related injuries.

Sources: Resident's clinical records; interviews with the PSW and DOC. [000715]

2) A resident did not have their falls prevention device applied as part of their care planned fall management interventions.

An observation revealed the resident did not have their falls prevention device applied.

A Personal Support Worker (PSW) indicated that they failed to apply the fall prevention device on the resident. The Director of Care (DOC) acknowledged that the falls prevention device was not applied as specified in the resident's care plan.

Failing to apply the resident's fall prevention device as specified in their care plan increased their risks of fall-related injuries.

Sources: Observations, resident's clinical records; interviews with the PSW and DOC. [000715]

3) A resident care plan noted for staff to ensure that a resident could locate their call bell. However, an observation revealed that the resident was left alone in their room with their call bell out of their reach.

A PSW confirmed that they did not place the call bell within the resident's reach when they left the resident in their room. The DOC acknowledged that the call bell was expected to always be within reach and accessible to the resident.

There was an increased risk of harm to the resident when the call bell was not within their reach as per their care plan.

Sources: Observations, resident's clinical records; interviews with PSW and DOC. [000715]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by someone or neglect of a resident by staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Rationale and Summary

There was an alleged incident of abuse and neglect of a resident by a staff in the home. However, the incident was reported to the Ministry of Long-Term Care (MLTC) the following day after the incident occurred.

The DOC acknowledged that the incident should have been immediately reported to the Director, and that failure to do so constituted late reporting.

Failure to immediately report alleged staff to resident abuse and neglect to the Director had no impact on the resident.

Sources: CIS Report; and interview with the DOC. [741670]

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program was implemented in the home to reduce the risk of injury to a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

Specifically, staff did not comply with their "Fall Management Policy", last revised March 2023, which was included in the licensee's Falls Prevention program.

Rationale and Summary
The home's Fall Management policy directed the registered staff to complete a specific assessment before the care staff transferred the resident following a fall.

A video record revealed that after the resident fell, they were transferred from the floor by two PSWs before the nurse performed the specified assessment.

The Director of Care (DOC) acknowledged that the specific assessment was not completed before the resident was transferred as per the home's policy.

Failing to complete the specific assessment before the resident was transferred increased their risk of injury.

Sources: Resident's clinical records, Fall Management Policy Tab 15, RC 15-01-01, Last revised March 2023, video recording; interview with the DOC. [000715]

COMPLIANCE ORDER CO #001 Altercations and Other Interactions between Residents

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents. The plan shall include but is not limited to:

- Education provided to a specific PSW on managing responsive behaviours, prevention of abuse and neglect, implementation of care plan interventions for responsive behaviours
- Monitoring of the PSW to ensure compliance to care plan directions
- Monitoring of a resident's potential risk of altercations with other residents
- The review and revision of the care plan of two residents specifically related to responsive behaviours in collaboration with staff and others who are involved in different aspects of their care, and the revisions communicated to the care staff who provide care to these residents
- Process to ensure behavioural interventions are implemented and remain effective in reducing behaviours and risk to residents
- Long term actions to reduce the risk of altercation between residents, including identification and implementation of interventions
- The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component mentioned above within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2024-1413-0002 to Chinonye Nwankpa (000715), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by May 9, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents, including identifying and implementing interventions.

Rationale and Summary
A resident's care plan noted they exhibited specific responsive behaviours and directed staff on interventions to prevent the behaviours.

A video record showed that the resident exhibited specific responsive behaviours towards another resident. The record also showed that a PSW who was present did not intervene.

The PSW confirmed that they failed to intervene when they observed the incident between the residents. The DOC acknowledged that the PSW failed to intervene when the incident was initially discovered.

The altercation led to both residents falling and one of them getting injured.

Sources: Residents clinical records, video record; interviews with the PSW and DOC. [000715]

This order must be complied with by June 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the

Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.

(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.