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: August 20, 2024
Inspection Number: 2024-1413-0003
Inspection Type: Complaint, Critical Incident and Follow up
Licensee: University Health Network
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 17, 20, 21, 24, 25, 27, 28, 2024 and July 2- 5, 8-12, 2024

The following Critical Incidents (CI) were inspected in this inspection:

- Intakes: #00113434, #00116988 - were related to a communicable disease.
- Intake: #00113960 - improper care of a resident.
- Intakes: #00114410, #00117216 - fall of a resident resulting in injury.
- Intakes: #00114669, #00115386 – alleged staff to resident abuse.

The following Follow-up order was inspected in this inspection:

- Intake: #00114754 - follow-up order related altercations and Other Interactions between Residents.

The following complaint was inspected in this inspection:

- Intake: #00119947 - a complaint related to staff hiring and onboarding process.

Previously Issued Compliance Order(s)

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

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Order #001 from Inspection #2024-1413-0002 related to O. Reg. 246/22, s. 59 (b) inspected by Slavica Vucko.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 9.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis.
The licensee has failed to ensure that there was a written plan of care for a resident that sets out the planned care for the resident.

Rationale and Summary

A resident was transferred to the hospital that required pharmaceutical and surgical interventions.

The resident indicted they had a history of a specific diagnosis before they were admitted and had informed the home of this. The home ordered two diagnostic tests; the results confirmed the resident's diagnosis.

A Personal Support Worker (PSW) and a Registered Nurse (RN) both indicated they were aware that the resident had the diagnosis. A RN and the Director of Care (DOC) both acknowledged that the resident's written plan of care did not have any interventions related to the resident's diagnosis.

The DOC confirmed the current listed interventions should have been in the resident's care plan.

Failure to ensure a resident's written plan of care had interventions related to their diagnosis placed them at risk for not having their needs met.

Sources: A resident clinical records, interviews with a resident, PSW, RN, and the DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care sets out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

A resident sustained a fall that resulted in injury. At the time of fall, there was a fall intervention in place but not on the side they fell.

Assessment by Physiotherapist (PT) on a certain date, indicated that the fall interventions were to be placed on both sides of the resident bed. The written plan of care for the resident indicated that a fall intervention was in placed but did not indicate application on both sides of the bed.

Interviews with a PSW and a Registered Practical Nurse (RPN) did not indicate awareness that the resident required two fall interventions, one on each side of the bed.

Failure of the home to ensure that a resident's written plan of care sets out clear directions related to implementation of fall intervention as per the PT recommendation placed the resident at risk of injury.

Sources: Observation, a resident's clinical record, policy Falls Prevention and Management Program RC-15-01-01 dated March 2023, interviews with a PSW, a RPN, PT, DOC, and RNs.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and

are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of the resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A resident sustained a fall from their bed that resulted in injury. The resident was using a specific intervention.

A PSW indicated the resident bed was elevated at the head and knee at night at an unknown degree. They noticed the resident was not staying in one position at night and had to reposition them. The PSW indicated they had reported this to registered staff some time ago.

The staff who did the post fall assessment of the resident, indicated they were able to move in bed. The PT indicated no referral was sent to them in order for the resident to be reassessed when in bed.

Failure of the home to communicate the observations of a resident's unsafe intervention in bed with the PT for further reassessment placed the resident at risk for falls.

Sources: Observation, a resident's clinical record, interviews with PSWs, RPN, PT, DOC, and RNs.

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2)

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that all employees received training before performing their responsibilities.

Rationale and Summary

A review of employees hired in 2024 direct-care Surge Learning results indicated some employees started their training and did not finish.

Review of two employee files revealed that they had not completed all of the required training prior to working in the home.

The Senior Executive Director (ED) stated there was a risk to residents' safety when employees failed to complete their required training.

There was potential risk to residents when employees providing care to residents did not complete their required training before performing their responsibilities.

Sources: Employees training records, excel file of employees hired in the past three months, interviews with PSWs and the ED.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary

On May 17, 2024, resident #004 presented with three respiratory symptoms. On

May 18, 2024, resident #003 presented with the same symptoms. Resident #003 was placed on additional precautions. Resident #004 was not placed on additional precaution and was wandering the unit. Resident #003's lab result received a week later indicated they were, positive for a communicable disease. Toronto Public Health (TPH) was contacted on May 21, 2024, and declared the home in a suspected outbreak. Resident #003 was placed on additional precaution and was encouraged to stay in their room. On May 21, 2024, the Infection Prevention and Control (IPAC) lead instructed the staff to wear a face mask, staff and residents to stay on the floor, passive screening for staff and to report if they were ill and not come to work and enhanced environmental cleaning of high-touch areas. On May 23, 2024, the home was declared in facility wide outbreak with residents affected on different floors.

As per the home's policy Outbreak Management, Droplet precautions, IC-03-01-09**,** residents who present with symptoms of an infection will be placed on droplet precautions, and staff should wear gloves, gowns, mask, and protective eyewear for staff. Registered staff will implement droplet precautions while awaiting test results and/or if an infection was suspected. Care staff to implement eye protection and masks - following routine practices immediately for a current resident in the home who has been diagnosed with or was suspected of having an illness requiring additional precautions.

Interview with the IPAC lead indicated that in the period from the second case presentation with signs and symptoms on May 18, 2024, until May 21, 2024, there was no environmental cleaning of high touch areas at least two times a day, no personal protective equipment (PPE) were worn by staff while providing care to resident #003.

Failure of the home to comply with the infection prevention and control program to take immediate action to reduce transmission placed the residents at increased risk for infection.

Sources: Interview with the IPAC lead, DOC, home's IPAC manual, policy #IC-03-01-09 from 2024, resident #004 and #004's clinical records, TPH outbreak checklist.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (12) 4.
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that staff were screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director under subsection (2).

Rationale and Summary

According to the Infection Prevention and Control (IPAC) Standard, s. 11.2, the licensee was required to ensure that staff were screened for tuberculosis and other infectious diseases at time of hire in accordance with evidence-based practices and where there were none, in accordance with prevailing practices.
In addition, the home's staff Immunization and tuberculosis (TB) testing policy stated upon hiring, all staff members must provide a copy of their immunization status

showing dates and results of their TB test completed before they began work. The home's immunization policy also stated employees who had not had a test done in the past year were required to have the test completed as a condition of hire. The test must be completed before the employee began work.

Review of three employee files revealed they did not have up to date TB test results at the time of being hired.

The home's ED indicated it was the home's responsibility for obtaining and validating the staff TB screening documents and maintain the results in the employees files.

There was potential risk to residents' health when the home did not verify that staff TB screening was completed before they began work.

Sources: Staff Immunization and Tuberculosis testing Policy IC-02-01-02 last reviewed January 2024, IPAC standards 2021, interview with three PSWs and ED.

WRITTEN NOTIFICATION: Staff records

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 1.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
The licensee has failed to ensure that a record was kept for three staff members of

the home, that included each staff member's qualifications, previous employment and other relevant experience.

Rationale and Summary

Review of three employee files revealed the home did not have their records of qualifications, previous employment and other relevant experiences.

The ED reviewed the three employee files and acknowledged each file was missing information related to qualifications, previous employment and other relevant experience.

They verified all records found in each staff file was everything the home had for the employee.

There was a potential risk that the staff may not have the relevant experience to ensure they were qualified for their roles when records were not available.

Sources: Three employees files, excel file of staff hired in the past three months and interview with the ED.

WRITTEN NOTIFICATION: Staff records

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 2.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
2. Where applicable, a verification of the staff member's current certificate of

registration with the College of the regulated health profession of which they are a member, or verification of the staff member's current registration with the regulatory body governing their profession.

The licensee has failed to ensure that records were kept for a registered nurse of the home that included verification of their current certificate of registration with the College of Nurses of Ontario (CNO).

Rationale and Summary

Review of an employee file revealed there was no documentation or verification that a registered nurse was in good standing with the CNO upon hire.

The ED acknowledged there were no documents of credentials in a registered nurse employee file to indicate they were in good standing with the CNO prior to their employment.

There was a potential risk to residents when the home did not have any documentation to indicate that a registered staff was in good standing with the CNO and had no restrictions to practice.

Sources: Review of employee member files, review of a registered nurse employee file, and interviews with the ED.

WRITTEN NOTIFICATION: Staff records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 3.
Staff records
s. 278 (1) Subject to subsections (2) and (3), every licensee of a long-term care home

shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
3. Where applicable, the results of the staff member's police record check under subsection 81 (2) of the Act.

The licensee has failed to ensure that a record was kept for each staff member of the home that includes the results of the staff member's vulnerable sector police check.

Rationale and Summary

Review of two employee files revealed that they did not contain a vulnerable sector police check.

Both employees indicated when they were hired, they provided the home with their vulnerable sector police checks, either by email or hard copies.

The ED acknowledged it was the responsible of the hiring department manager, to ensure vulnerable sector police checks were completed and copies retained in the employee files. The ED verified that the two employee files did not contain their vulnerable sector police checks. They were unable to indicate if a vulnerable sector police check was completed for the two staff.

It is reasonable to conclude that by not having the results of a police record check on file for the two employees may put residents at risk.

Sources: Review of two employee files, interviews PSWs and the ED.