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

Central East District
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Original Public Report

Report Issue Date: May 17, 2023

Inspection Number: 2023-1710-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Lakeridge Health

Long Term Care Home and City: Lakeridge Gardens, Ajax

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2023.05.19 15:02:06 -04'00'

Additional Inspector(s)
Julie Mercer (000737)
Holly Wilson (741755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 28 - 31, April 3 - 6, April 11 – 14 with April 11 – 13, 2023 conducted onsite and April 14, 2023, conducted offsite, and April 17 - 19, 2023.

The following intake(s) were inspected:

- Intakes #00002108, #00012756, #00005113, #00005674, #00013339, #00013343, and #00004541 related to responsive behaviours.
- Intake #00021178 related to falls prevention and management; and intakes #00005360, #00007146, #00013212, #00016856, #00018280, and #00020404 related to an injury with a significant change in condition.
- Intake #00012099 related to an unexpected death.
- Intake #00007947 related to a complaint regarding plan of care.
- Intake #00011845 related to a complaint regarding weight loss and plan of care.
- Intake #00019792 related to a complaint regarding assessments not being completed and improper care.
- Intake #00021098 related to a complaint regarding an allegation of verbal abuse not being reported.
- Intake #00005131 related to a complaint regarding responsive behaviours.

- Intake #00005334 related to a complaint regarding admission protocols and medication administration.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)

The licensee failed to ensure that specific equipment for falls prevention and management was readily available for a resident.

Summary and Rationale
A Critical Incident report was submitted to the Director to report a resident's fall, which resulted in a significant change in the resident's health condition.

The care plan for the resident indicated they were at risk for falls and included an intervention to provide specific equipment for falls prevention and management.

An observation identified that the specific equipment was not in place for the resident. A Registered Nurse (RN) confirmed that the resident should have the equipment. The RN searched the resident's room and was unable to locate the equipment. The RN indicated they would contact the Resident Care Manager (RCM) to request the equipment for the resident.

In an interview, the Director of Care (DOC) confirmed that the resident should have the specific equipment for falls prevention and management, as stated in the resident's care plan.

Failing to ensure the specific equipment was readily available for the resident, as specified in the plan of care, increased risk for the resident related to falls prevention and management.

Sources: Interviews with staff, resident's care plan, observations.
[706026]

WRITTEN NOTIFICATION: Dining and Snack Services

NC # 002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of a resident who required assistance.

Summary and Rationale
A complaint was received by the Director.

Review of the resident's plan of care identified the resident required total assistance with eating, and the resident was at high risk for nutritional status.

During two separate dining and snack observations, it was identified that the resident was not in a safe position while two different PSWs assisted the resident.

In an interview, a Registered Practical Nurse (RPN) indicated that at mealtimes residents should be sitting up at a 90-degree angle. In an interview, the physiotherapist specified that the expectations are for the residents to be upright for mealtimes and snacks, to facilitate chewing and swallowing.

Failing to ensure proper techniques were used to assist with eating, including safe positioning of a resident who required assistance, put the resident at increased risk of harm.

Sources: Observations, resident's plan of care, interviews with staff.
[706026]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC # 003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)

The licensee failed to ensure that an alleged incident of resident-to-resident abuse was immediately investigated.

Summary and Rationale
A Critical Incident was reported to the Director for an allegation of resident-to-resident abuse.

On a particular date, an alleged incident of resident-to-resident abuse occurred. Review of a resident's progress notes indicated no documented evidence of the alleged abuse incident, no assessments, and no investigation.

An interview with an RN confirmed that the resident received an assessment but they did not ask any questions of the resident nor begin an immediate investigation. The RN also confirmed that they did not call the police. In an interview, the Administrator confirmed that an investigation should have been immediately initiated, and the police should have been informed of the incident. An interview with the BSO RPN confirmed that they were aware of this incident and acknowledged that no documentation or investigation had occurred.

Failure to immediately investigate an allegation of abuse resulted in the resident being placed at risk for further abuse.

Sources: Critical Incident Report, resident's progress notes and care plan, interviews with staff. [741755]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC # 004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee failed to ensure that a resident's weight was measured and recorded on admission and monthly thereafter.

Summary and Rationale
A complaint was received by the Director expressing concern regarding a resident's weight loss and the care of the resident.

Review of the clinical record for the resident indicated that there were no documented weights for two consecutive months.

The resident's care plan indicated the resident was assessed as high nutritional risk with a history of

significant weight loss.

During interviews, two RPNs and an RN indicated it was required for the residents to be weighed monthly and the weights are to be documented in the residents' clinical records. In an interview, the DOC confirmed they were unable to find the monthly weights documented for the two consecutive months for the resident.

Failing to ensure that the resident's weight was measured and recorded monthly put the resident at increased nutritional risk, as the resident had a history of significant weight loss.

Sources: Resident's clinical record and care plan, interviews with staff.
[706026]

WRITTEN NOTIFICATION: Licensees who report investigations under 27 (2) of Act

NC # 005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 1.

The licensee failed to submit a report to the Director for an alleged incident of resident-to-resident abuse.

Rationale and Summary
An After Hours call by the home to the Director was received concerning an alleged incident of resident-to-resident abuse. Both residents were separated and assessed. Police, Director of Care (DOC), and Substitute Decision Makers (SDM) for both residents were notified of the incident.

During an interview with an RN, they confirmed the acting DOC was in the home at the time of the incident. Interviews with an RN and the Administrator confirmed the home did not submit a written report to the Director concerning the critical incident.

Failure of the licensee to immediately report alleged, suspected or witnessed abuse of a resident placed the resident at risk of further harm.

Sources: Ministry of Long-Term Care Homes Portal, Progress notes for the residents, interviews with staff.
[741755]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC # 006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Summary and Rationale
A complaint was received by the Director expressing concern regarding a resident's weight loss and the care of the resident.

The care plan for the resident included a goal with specific interventions for Occupational Therapy (OT) and Physiotherapy (PT) to monitor the use of two devices and provide assistance to unit staff for proper and safe use of the devices daily.

During two separate observations of the resident on two different dates, it was identified that the devices were not in use. The PT attended the resident's room to look for the devices and any posted instructions regarding the use of the devices. The PT found one device in the resident's room and indicated there should be two. The PT was unable to find the other device, and unable to find any posted instructions regarding the use of the devices.

When asked by the inspector, a PSW indicated the devices were no longer in use for the resident and hadn't been in use for a few months. In an interview, an RPN indicated the resident used to have the devices and there was some difficulty with the devices.

In an interview, the PT specified that the devices were still in use and were to be used when the resident was up, and removed at nighttime. The PT indicated there was no order to stop the use of the devices and that they would follow up with the Occupational Therapist.

The Administrator communicated that if the resident's needs changed, the expectation was for an assessment by OT, orders from OT or the physician, and the Care Plan should have been reflective of the current state.

In failing to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, the resident was at risk.

Sources: Resident's Care Plan, observations, interviews with staff.
[706026]

WRITTEN NOTIFICATION: Consent

NC # 007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7

The licensee failed to ensure that consent was obtained from a resident's Substitute Decision Maker (SDM) when the resident's plan of care was reviewed and revised to include the prescribing of a new medication.

Summary and Rationale
A complaint was received by the Director indicating the resident was treated with a newly prescribed medication without the SDM's consent.

The physician prescribed the medication for the resident. In an interview, an RN stated they were on shift when a visitor noticed the medication had been administered to the resident and asked about it. The RN explained that the medication was administered the previous night.

In an email, the Resident Care Manager (RCM) apologized to the resident's SDM for the staff not contacting them to obtain consent, prior to the new medication being administered.

In interviews, an RN and the DOC confirmed that the expectation was for the SDM to be contacted for each resident prior to the administration of a new medication.

Sources: Resident's progress notes, Treatment Administration Record (TAR), Physician's Order, email communications, and interviews with staff.
[706026]

WRITTEN NOTIFICATION: Responsive Behaviours

NC # 008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)

1) The licensee failed to ensure that strategies were developed or implemented for a resident who was

known to exhibit responsive behaviours.

Rationale and Summary
A Critical Incident was reported to the Director regarding an allegation of abuse by the resident toward another resident. Review of the resident's progress notes identified another incident of alleged abuse by the resident toward a co-resident had occurred on a different date.

The Substitute Decision Maker (SDM) of the resident had voiced concerns about co-residents' behaviours towards the resident. It was documented in the progress notes of the resident, that the resident expressed responsive behaviours.

The SDM raised concerns about the co-residents' behaviours toward the resident a second time and requested a change for the resident, which was granted.

An RN was making rounds with a PSW and discovered the resident in an altercation with a co-resident. Both residents were separated and assessed.

The BSO RPN authored a Behavioral Support Tip Sheet for strategies and approaches to respond to the resident's responsive behaviours. The care plan was updated to reflect a focus on responsive behaviors and the need to identify possible triggers.

Interviews with an RN indicated that they were not aware of any specific responsive behaviours for the resident. An interview with the BSO RPN, confirmed the resident was on a monitoring system for responsive behaviours and specific behaviours were identified but the care plan was not updated until after an altercation occurred. The RCM, an RN, the BSO RPN and the Administrator confirmed there was not an updated plan of care for the resident with a focus on specific responsive behaviours towards co-residents at the time of the critical incident.

Failure to update the plan of care for the resident to ensure that strategies were developed or implemented for the known responsive behaviours, placed co-residents at risk of harm.

Sources: Resident's progress notes, plan of care, behavior assessments and documentation, interviews with staff.
[741755]

2) The licensee failed to ensure that a resident who was known to exhibit responsive behaviours had interventions implemented to safeguard the resident.

Rationale and Summary:
Critical Incident Reports (CIRs) were submitted to the Director regarding two alleged incidents of abuse toward the resident, by two different co-residents.

Record review of the plan of care for the resident did not indicate any strategies to safeguard the resident following the first and second alleged abuse incidents by co-residents.

Interviews with the Administrator and the DOC indicated that the plan of care for the resident needed to be updated following any incident and when the care needs of the resident changed. The BSO RPN confirmed that they were aware of the two incidents and were able to make changes to the plan of care, but did not do so.

Failure to update the plan of care for the resident to include interventions to safeguard the resident placed the resident at increased risk of vulnerability.

Sources: Critical Incident Report**,** resident's plan of care, interviews with staff.
[741755]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC # 009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1. The licensee failed to ensure an allegation of verbal abuse by staff toward a resident was immediately reported to the Director.

Summary and Rationale
A complaint was received by the Director alleging there was an unreported incident of verbal abuse by staff toward a resident.

A Critical Incident Report (CIR) was submitted to the Director, reporting the allegation of verbal abuse of the resident by staff, over two months after the alleged incident occurred. The CIR indicated that an RN became aware of the allegation on the same date the alleged incident occurred.

In interviews, a PSW and the DOC both confirmed they became aware of the allegation of verbal abuse of the resident by staff on the same date the alleged incident occurred. Email communications confirm the Administrator’s awareness of the alleged incident.

In an interview, the DOC indicated that the allegation of abuse should have been reported immediately, on the date the long-term care home became aware of the allegation.

In failing to immediately report an allegation of verbal abuse of a resident, there was low risk to the resident.

Sources: Critical Incident Report, email communications, interviews with staff.
[706026]

2. The licensee failed to ensure it was immediately reported to the Director when there was an alleged incident of resident-to-resident abuse.

Rationale and Summary
A Critical Incident Report was submitted to the Director, with an allegation of resident-to-resident abuse.

On a particular date, staff observed a resident-to-resident altercation. Staff intervened and removed both residents. A Critical Incident Report was submitted to the Director to report the alleged incident five days later.

In an interview with an RN, they indicated they were aware of the Abuse Prevention and Management Policy and their Duty to report any alleged, suspected or witnessed abuse. An interview with the Administrator and the DOC confirmed that the MLTC After Hours line should have been called and the Director should have been notified immediately at the time the incident occurred.

Failure to immediately report an allegation of abuse of a resident, was a low risk to the resident.

Sources: Critical Incident Report, interviews with staff.
[741755]

WRITTEN NOTIFICATION: Police Notification

NC # 010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

1. The licensee failed to ensure that the appropriate police service was immediately notified of any

alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary
A Critical Incident was reported to the Director for an alleged witnessed resident-to-resident abuse incident.

A resident's progress notes indicated that the resident continued to express behaviours with staff and co-residents.

On a particular date, staff observed a resident-to-resident altercation. Staff intervened and removed both residents. The residents' progress records indicated no police report was made.

In an interview with an RN, they indicated that no police were called. In an interview with the Administrator and the DOC, they confirmed that police should have been contacted.

Failure to contact police following an alleged witnessed incident of resident-to-resident abuse put the resident at risk of further abuse.

Sources: Critical Incident Report, residents' progress notes, interviews with staff.
[741755]

2. The licensee failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary
A Critical Incident was reported to the Director for an alleged incident of resident-to-resident abuse.

A resident was the recipient of specific behaviours by a co-resident on two separate occasions. Review of the resident's progress notes indicated no documentation that the police were notified of the abuse incident.

An RN confirmed they did not call the police. An interview with Administrator confirmed that the police should have been notified and documented for both residents.

Failure to contact police placed the resident at risk of further abuse.

Sources: Critical Incident Report, residents' clinical records, interviews with staff.
[741755]