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 26, 2023	
Inspection Number: 2023-1710-0003	
Inspection Type: Complaint	
Licensee: Lakeridge Health	
Long Term Care Home and City: Lakeridge Gardens, Ajax	
Lead Inspector Holly Wilson (741755)	**Inspector Digital Signature** Holly N Wilson Digitally signed by Holly N Wilson Date: 2023.05.26 13:20:52 -04'00'
Additional Inspector(s) Julie Dunn (706026)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 28-31, April 3-6, 2023.

The following intake(s) were inspected:

- One complaint related to an improper transfer of a resident

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

Staffing, Training and Care Standards
Reporting and Complaints
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 (1)

The licensee failed to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices, and assistive aids.

1. Rationale and Summary:

The home's Falls prevention and Management Program specifically the Post Fall Huddle indicated:

1. Post Fall Huddle as soon as possible, ideally within the hour and complete a post fall assessment as soon as possible. Nurse to coordinate huddle and lead discussion. Document this as part of the incident report/huddle.

On a specific day, a resident sustained a fall. The post fall huddle was completed sixty-one days later.

During separate interviews with Resident Care Manager and Falls Lead (RCM) and Administrator, confirmed that the post fall huddle was completed and documented sixty-one days after the fall and should have been completed as soon as possible, ideally within the hour.

Failure to complete a post fall huddle places residents at risk if identified interventions are not put into place because of the fall.

Sources: Post Fall Huddle Documentation of a resident, Falls Prevention and Management Program Policy, interviews with RCM, and Administrator.

2. Rationale and Summary:

The home's Falls Prevention and Management Program policy indicated:

For seventy-two hours, post fall:
1. Assess the following at each shift: Pain, Bruising, Changes in range of motion

2. Notify the physician/NP if there is a sudden change in vital signs and/or neurological assessment, or if the resident: is nauseated or vomits, has progressive weakness, or has an elevated temperature.

Clinical Records indicated the following:

On a specific day, a resident suffered a fall. The resident immediately complained of pain in their shoulder when assessed by the RN and the pain assessment indicated no medications were administered. On the same day, the resident had a vomiting episode. Over the next six days, the resident was administered medication for pain and the medication was effective to reduce pain on four of seven occasions. There was no evidence of further action when the medication for pain was ineffective.

On a specific day, the resident developed a fever and medication to reduce the fever was administered and documented as being effective.

On a specific day, the resident was unable to move and had decreased range of motion (ROM). The Nurse Practitioner (NP) assessed the resident and wrote an order for an x ray. The x ray requisition was faxed to the mobile x ray department, but no x ray was completed in the home.

On a specific day, the resident experienced severe pain, rated by the resident as ten out of ten and was sent to the hospital for an x-ray where it was discovered that the resident had sustained a fracture.

Interviews with Administrator and RPN indicate that the Physician/NP should have been notified immediately after episodes of pain, swelling, vomiting, and fever.

Failure to follow the home's policy for seventy-two hours post-fall and contact the Physician/NP when resident experienced pain, swelling, vomiting and fever, resulted in delayed treatment for the sustained fracture.

Sources: Resident's progress notes, the home's Falls Prevention and Management Policy, interviews with Administrator and RPN.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary:

A Critical Incident report (CIR) was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to the hospital, and which resulted in a significant change in the resident's health status.

The RN was informed by two personal support workers (PSW), that an improper transfer had occurred involving a resident, who was weak and could not hold onto the device used to transfer residents. The resident had the belt fully fastened and connected to the device used to transfer residents on one of two sides at the time of the incident. The resident sustained a fall when the two PSW's began the transfer with the belt being fastened only on one side of the device used to transfer residents.

Interviews with PSW and Clinical Practice Leader confirmed the resident was incorrectly attached to the device used to transfer residents resulting in an improper technique to transfer the resident. PSW and Clinical Practice Leader considered this to be a fall.

Failure to ensure that the staff used safe transferring when assisting residents resulted in the resident experiencing a fall which resulted in an injury causing a significant change in the resident's health status.

Sources: CIR, a Resident's investigation notes, interview with PSW, RN.

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WRITTEN NOTIFICATION: Staff Qualifications

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79

The licensee failed to ensure that all staff of the home,
(a) had the proper skills and qualifications to perform their duties; and
(b) possessed the qualification provided for in the regulations.

Rationale and Summary

On December 24, 2022, the home contracted an agency to provide nursing services and Agency PSW was sent to the home. The Agency PSW did not possess a certificate as a Personal Support Worker, however, was enrolled in a nursing program in Canada.

In an interview with the Staffing Clerk, they confirmed that they contracted staff from the home's preferred nursing agency providers. In an interview with the Administrator, acting Director of Care role on December 24, 2022, they confirmed that the home's Human Resources Department did not hire nursing students to act in the role of a PSW and that there was no verification of qualifications to ensure that Agency PSW had adequate skills and qualifications to perform the duties of a personal support worker, prior to them working in the home.

Failure to ensure that staff had adequate skills and qualifications to perform the duties of a personal support worker posed a risk to the resident's health and welfare.

Sources: Agency documents, Interviews with Staff and Administrator.

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WRITTEN NOTIFICATION: Notification re Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee failed to ensure that the resident's substitute decision maker (SDM), if any, and any other person specified by the resident was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Rationale and Summary

On a specific day, a resident suffered a fall and the SDM was not contacted. During a visit with the SDM, the resident relayed the events of what occurred on a specific day. The SDM was upset and spoke to RPN at the time of discovery. The SDM indicated they left a voice message for the Social Worker, as the SDM was unable to reach any other staff at the home. The SDM also emailed the Social Worker afterword, identifying they wished to be notified any time the resident experienced a fall or any other change in condition.

The resident's progress notes indicated that they experienced a fall on a specific day and the SDM was not notified until the following day, when the SDM visited the home.

Failure to communicate with the SDM placed the resident at increased risk for detriment of health, well-being and advocacy of quality of life.

Sources: emails to the home from the SDM, voicemail message recordings, interview with Social Worker, Resident's progress notes.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5), where an incident occurs that causes an injury to a resident for which the resident is taken to the hospital and that results in a significant change in the resident's health condition.

Rationale and Summary

On a specific day, a resident sustained a fall. Six days later, the resident was transferred to the hospital where it was determined that the resident had a fracture and received treatment. Nine days later, the resident required surgical intervention of the fracture. The CIR was submitted to the Director several days later.

In an interview with the Administrator who submitted the CI, they confirmed this was late reporting.

Failure to immediately report Critical Incidents to the Director inhibits transparency and communication with the Director.

Sources: CIR, review of clinical records for a resident, Interview with Administrator.

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WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1

The licensee failed to ensure that training was provided to all staff who provided direct care to residents: specifically related to Falls Prevention and Management.

Rationale and Summary

FLTCA, 2021, s. 2(1) defines "staff", in relation to a long-term care homes, means person who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (“personnel”).

A CIR was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital, and, which resulted in a resident sustaining a fracture which required surgical intervention.

The Clinical Practice Leader confirmed that their role is to provide orientation to staff, and students. The RN verified the home had an Agency Policy and Procedure and that no orientation was provided to the Agency RN and Agency PSW. Both Agency staff had not completed Falls and Prevention and Management Education prior to working in the home.

Failure to orient agency staff on the home’s Falls Prevention and Management Program, placed residents at risk of improper transfers.

Sources: Agency Staff Policy and Procedure, interview with staff.

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