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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 13, 2023	
Inspection Number: 2023-1710-0004	
Inspection Type: Critical Incident	
Licensee: Lakeridge Health	
Long Term Care Home and City: Lakeridge Gardens, Ajax	
Lead Inspector Diane Brown (110)	**Inspector Digital Signature** Diane Brown Digitally signed by Diane Brown Date: 2023.10.27 14:26:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 7-8, 11-14, 20, 2023.

The following intake(s) were inspected:

- Intake: #00094482 - related to an unexpected incident leading to a resident's death.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating the presence of infection for resident #002 were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

Resident #002's health record identified them with the presence of an infection positive and they were subsequently placed on isolation precautions. Nine days later while still on isolation precautions, a review of the resident's progress notes, along with IPAC lead #113, identified that staff had not recorded, on any shift, for seven days, if the resident was symptomatic or asymptomatic of this infection confirming there was no evidence of the resident's infection being monitored. RPN #110 confirmed it was the practice to document an infection note, each shift, for the purposes of monitoring for signs of infection. The IPAC Lead confirmed it was the homes' policy that nursing staff document every shift an infection note related to the monitoring of symptoms of infection. The lead further added that monitoring of resident #002, to determine whether they are asymptomatic or symptomatic, was required prior to removing isolation precautions.

A review of the homes' "Surveillance Policy", also required nursing staff to complete a daily surveillance form. The form was located at the nursing station and required nursing staff to assess residents, each shift, for signs and symptoms of infection and to initial the form. Registered Practical Nurse #110 and RN supervisor #112 confirmed this practice in the home, however RPN #111 was unaware of the daily surveillance form. The daily surveillance form was reviewed along with IPAC Lead #113. For the 13 days prior, the form was blank, on all shifts, without staff initials.

Resident #003 was at risk for prolonged isolation when their infection was not being monitored on every shift. Further, the failure to complete the daily surveillance form may not support the early detection of signs of infection that can lead to outbreaks.

Sources: Resident #002 progress notes, the home's Surveillance Policy # LTC-IPAC-05, dated March 29, 2022, Daily Surveillance Form from 2 West, interviews with RPN #110, #111, RN supervisor #112 and

IPAC Lead #113. [110]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)

The licensee failed to ensure that the home was equipped with a resident to staff communication and response system that was on at all times.

Summary and Rationale

A Critical Incident (CI) report was submitted to the Director for an incident involving resident #001.

The Environmental Services Manager and Resident Care Manager #114 both indicated the homes' resident to staff communication and response system, was designed to include the use of an 'Austco Pulsemobile' portable phone to alert staff as to when and where a call bell had been activated and required staff to carry a phone for their entire shift. The system also included a light in the hallway, above the resident's door and a light upon entering the hallway that both turned on when a call bell was activated. There was also a marquee board at the nursing station that indicated the resident room number or location of the call bell that was being activated and included a beep sound every minute.

The progress notes for resident #001 indicated that RPN #102 was told by Personal Support Worker (PSW) #101, while in the dining room, that resident #001 was having an emergency incident. An interview with PSW #101 shared that they had just left the resident in their room and returned to the dining room when they saw the resident had activated their call bell for assistance. The PSW shared they were not carrying their portable phone at that time but became aware of the resident's call when they saw the marquee board at the nurse's station, adjacent to the dining room.

There was a risk of a delayed response to resident #001's emergency when PSW #101 had not carried the assigned portable phone allowing for a timely method of knowing the resident was requesting assistance.

Sources: resident #001's progress notes, observations of unit and communication system and interview with staff (PSW #101, Environmental Services Manager and Resident Care Manager #114). [110]

WRITTEN NOTIFICATION: Dining and snack service

NC #003 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 resident #001 with eating, including safe positioning of residents who required assistance.

Summary and Rationale

A CI report was submitted to the Director for an incident involving resident #001.

Review of resident #001's plan of care indicated the resident was to be provided all meals in an area outside of the dining room and required set up and assistance with their meal.

During an interview with Registered Practical Nurse (RPN) #102, they indicated responded to resident #001 when PSW #101 informed them the resident was in distress. The RPN described the resident sitting at an approximate 75 degree angle. They revealed they then positioned the resident to an approximate 90 degree angle.

In separate interviews both the Nurse Practitioner (NP) and Registered Dietitian (RD) #107 confirmed that resident's eating in areas outside of the dining room were required to be also positioned safely and as close to angle of 90 degrees as possible to reduce the risk of unsafe swallowing.

Failing to ensure safe positioning techniques were used to assist resident #001 with eating, unsupervised, placed the resident at risk of unsafe swallowing.

Sources: resident #001's plan of care and staff interviews (RPN #102, Nurse Practitioner and Registered Dietitian #107). [110]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The licensee failed to ensure resident #001's plan of care was based on an interdisciplinary assessment of the resident's safety risk.

Summary and Rationale

A CI report was submitted to the Director for an incident involving resident #001.

Review of resident #001's plan of care required them to be provided with set up assistance for meals and to provide all meals in a preferred manner. The resident also required a modified fluid consistency diet. No safety risks were identified.

In separate Interviews with PSWs #104 and #101 they both shared that the resident had a manner of eating that was a concern to eating safety. Both staff were unaware of the reason why the resident required a modified fluid consistency diet.

An interview with the NP stated the resident was at risk of unsafe swallowing and that along with considering other behaviors, initiated an order for a modified fluid consistency diet. The NP also identified that eating in the manner the resident preferred further posed a safety risk.

A further interview with RD #107 identified that any resident eating meals in the manner that resident #001 had meals was a safety risk to unsafe swallowing and confirmed that resident #001's plan of care did not address this safety risk.

Failing to ensure resident #001's plan of care was based on an assessment of their safety risks related to their preferred manner of having meals and their unsafe eating pattern placed the resident at risk of unsafe swallowing.

Sources: resident #001's plan of care and staff interviews (PSWs #104, #101, NP, RD #107) [110]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Update the home's pleasurable dining policy to include the PSW/registered staff responsibilities for monitoring residents at mealtimes including for those eating outside of the dining room;
2. For residents requiring tray service the plan of care must provide clear direction how the resident is to be positioned;
3. Perform weekly audits during meal service to ensure residents eating outside the dining room are monitored according to the home's pleasurable dining policy for 4 weeks;
4. Document the audits and actions made based on audit results.

Grounds

The licensee failed to ensure that resident #001 was monitored during meals.

Summary and Rationale

A CI report was submitted to the Director for an incident involving resident #001.

Review of resident #001's plan of care indicated the resident was to be provided all meals in an area identified outside of the dining room and required set up and assistance with their meal. The resident also required modified consistency fluids.

Interview with the Nurse Practitioner confirmed the resident required thickened fluids based on their assessment and concerns of safe swallowing.

With information made available to the Inspector evidence was provided revealing resident #001 was provided a meal by PSW #101 in an area unsupervised. PSW #101 confirmed they did not remain with the resident for their meal which was further confirmed by PSW#104.

The Home's policy 'Pleasurable Dining' required residents to be monitored during meals to promote residents' safety and to monitor the residents' overall response.

An interview with the Resident Care Manager/Clinical Practice Leader confirmed that the resident's eating in areas outside the dining room were expected to be served after the main dining room service was completed so they could be monitored.

Failing to provide monitoring of resident #001 during their meal, while they were eating in an area outside of the dining room placed the resident at risk of unsafe swallowing.

Sources: resident #001's plan of care, Pleasurable Dining policy (LTC-FOOD-05-dated March 22, 2022), and interview with staff (PSW #101, #104, Nurse Practitioner and Resident Care Manager/ Clinical Practice Leader #114). [110]

This order must be complied with by

November 10, 2023

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.