Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1710-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Lakeridge Health	
Long Term Care Home and City: Lakeridge Gardens, Ajax	
Lead Inspector Natalie Jubian (000744)	**Inspector Digital Signature**
Additional Inspector(s) Fatemeh Heydarimoghari (742649) Vernon Abellera (741751) Reethamol Sebastian (741747)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16 to 20, 23 to 25, and 27, 2023.

The following intake(s) were inspected:

- Intakes related to complaints regarding multiple care items.
- Intake related to improper resident care.
- Intakes related to alleged resident-to-resident abuse.
- Intakes related to alleged staff to resident abuse.
- Intakes related to complaints regarding resident care

- Intake related to improper resident care
- Intake related to a complaint regarding infection prevention and control.
- The following intakes were completed in this inspection: intakes related to resident fall with injury.

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

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

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) 19. ii.
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:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that a resident's right to refuse care was fully respected as required by law.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged staff to resident abuse incident. The resident's clinical records indicated a staff member reported to the unit nurse that the resident made negative comments toward and hit staff while providing care.

The CIR indicated the resident recalled the incident, wherein they had asked the staff member to leave the room after being woken up by them. The resident proceeded to grab the staff's arm and the staff physically abused the resident.

The home's internal investigation notes indicated that the staff member was retrained on the resident's bill of rights after the incident.

Resident Care Manager (RCM) #111 confirmed that the morning after the incident, the resident stated that they did not like waking up during the night and asked the staff member to leave the room.

Attempting to provide care to the resident when they refused, interfered with their rights, and caused distress to the resident.

Sources: CIR, resident's clinical records, interviews with RCM #111 and the resident. [742649]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care is based on the needs and preferences of a resident.

Rationale and Summary

A CIR was submitted to the Director indicating a resident asked a staff member to leave the room after being woken up by them. The resident proceeded to grab the staff member's arm The resident proceeded to grab the staff's arm and the staff physically abused the resident.

Analysis and follow-up in the CIR indicated that the resident's care plan was updated to two-person care, not to wake the resident up during the night, to allow a natural wake-up, and to have the resident call for assistance when needed. Upon review of the resident's care plan, none of the interventions had been updated.

RCM #111 confirmed that the resident's care plan was not updated based on the resident's needs and preferences.

Failure to update the resident's care plan placed the resident at risk of further incidents.

Sources: Resident's clinical records, interview with RCM #111. [742649]

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

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

Rationale and Summary

A CIR was submitted to the Director regarding an alleged incident of neglect that resulted in a resident's fall.

The home's investigation notes documented a staff member had entered a resident's room to provide care, however the resident became agitated. The staff member left the room, leaving the resident, who was a risk for falls, in bed, with the door closed, without applying the falls prevention intervention as per the resident's plan of care. Subsequently, the resident sustained a fall.

RCM #105 confirmed that the staff member had not followed the resident's plan of care.

Failing to ensure that the resident's plan of care was followed, put the resident at risk for a fall.

Sources: Clinical records, home's internal investigation notes, CIR, interviews with staff. [000744]

2. The licensee was required to ensure that a resident's prescribed procedure was administered in accordance with the directions specified by the prescriber, as per their plan of care.

Rationale and Summary

A CIR was submitted to the Director related to a resident 's medical device. The resident's care plan documented the Nurse Practitioner (NP)'s order to perform a procedure for specimen collection.

The resident's clinical records indicated the registered staff had used the incorrect medical device. The resident was transferred to hospital to alleviate the discomfort caused by the incorrect medical device. The resident returned to the home the same evening with medication prescribed to treat an infection as a result of the incident.

The NP and Director of Care (DOC) confirmed that the plan of care was not followed appropriately, resulting in discomfort and hospitalization of the resident.
Failure to follow the plan of care placed the resident at risk of injury and exposure to infection.

Sources: Clinical records, CIR, Interviews with NP and DOC. [741751]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

1. The licensee failed to protect a resident from neglect by a staff member.

Section 2 of O. Reg. 246/22 s. 7 defines neglect as "the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes in action or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A CIR for an incident of neglect was received by the Director that a resident had been left on the ground after a fall without notifying the registered staff.

The home's investigation notes documented, the staff member had entered the resident's room to provide care, however the resident became agitated. The staff member left the room, leaving the resident, who was a risk for falls, in bed, with the door closed, without applying the falls prevention intervention as per the resident's care plan. Subsequently, the resident sustained a fall, and the staff member did not report the fall or the resident's behavior to the registered staff, delaying an assessment to the resident.

RCM #105 could not identify how long the resident had been left unattended and confirmed the home's investigation concluded that the staff member had neglected the resident.

Failing to report the resident's fall to a registered staff member placed the resident at an increased risk of injury.

Sources: Clinical records, home's internal investigation notes, interviews with staff. [000744]

2. The licensee failed to ensure that a resident was protected from physical and emotional abuse by a staff member.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain. Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living unless the force used is excessive in the circumstances.

Section 2 of the Ontario Regulation 246/22 defines emotional abuse as, (b) "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Rationale and Summary

A CIR was submitted to the Director alleging emotional and physical abuse toward a resident.

The resident's clinical records indicated that the resident's cognitive status memory was intact, and they could make decisions consistently and reasonably. The home's investigation notes indicated that the resident reported to RCM #111 that a staff member was rough during care, which caused pain, neglected a call bell, and was always negative. The resident confirmed the abuse happened and mentioned being negatively impacted emotionally by the staff member. RCM #111 acknowledged the resident's cognitive status was stable at the time of reporting the incident.

Failing to protect the resident from abuse by staff resulted in pain and a risk to the resident's safety and well-being.

Sources: CIR, home's internal investigation notes, and interviews with the resident and RCM #111. [742649]

3. The licensee failed to ensure that a resident was protected from neglect.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A complaint was submitted to the Director related to a resident's injury.

The resident's clinical records indicated that the resident spilled a hot beverage on their lap during the morning snack cart at 1000 hours (hrs). The resident's Substitute Decision Maker (SDM) reported the injury to registered staff at 1130 hrs. However, assessment and treatment did not start until 1300 hrs.

A Registered Practical Nurse (RPN) stated a staff member did not assist the resident with the hot beverage as instructed. The towel was noted on the resident's lap at 1130 hrs and was not immediately reported to registered staff. The RPN sent an email to the manager, including this information, after the discovery of the incident.

RCM #105 confirmed they received an email and acknowledged the assessment and treatment started for the resident at 1330 hrs.

Failing to protect the resident from abuse and neglect resulted in the resident not receiving an assessment and treatment on time.

Sources: Clinical records, interviews with and RCM #105 and RPN. [742649]

4. The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary

A CIR was submitted to the Director regarding an alleged resident to resident physical abuse incident wherein a resident punched another resident in the face, resulting in injury.

The residents' clinical records indicated both residents had responsive behaviours which were managed by the Behavioural Support of Ontario (BSO) team at the home. Both residents were in the hallway when they got into a verbal altercation which triggered the incident. The residents were separated immediately afterwards and closely monitored. The resident who was punched sustained an injury.

Staff acknowledged the incident was considered physical abuse as it resulted in injury to the resident who was punched.

Failing to protect the resident from physical abuse from the other resident put them at risk for injury.

Sources: Clinical records, interviews with staff, CIR. [000744]

5. The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary

A CIR was submitted to the Director regarding an alleged resident to resident physical abuse wherein a resident punched another resident on their extremity, resulting in injury.

The resident, who had been punched, indicated a verbal altercation occurred between themself and the other resident This agitated the other resident causing them to punch the resident twice.

The resident confirmed they were physically abused by the other resident as the punch caused pain and resulted in injury.

Failing to protect the resident from physical abuse from the other resident put them at risk for injury.

Sources: Clinical records, interview with resident, CIR. [000744]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A CIR was submitted to the Director, related to alleged staff to resident physical abuse. The resident's clinical records indicated that the resident reported to staff that they were slapped by a staff member.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect- Response and Reporting" indicated to "Ensure the safety of and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs."

The resident's clinical records indicated no skin head-to-toe assessments were done immediately after the alleged staff to resident physical abuse incident.

The DOC acknowledged that a skin head-to-toe assessment was part of the full assessment.

RCM #111 confirmed that the skin head-to-toe assessment were part of the full assessment, and no skin head-to-toe assessment was completed for the resident after the alleged physical abuse.

Failure to assess the resident's skin placed them at potential risk of skin integrity issues.

Sources: Clinical records, home's "Zero Tolerance of Resident Abuse and Neglect- Response and Reporting" policy, interviews with staff. [742649]

2. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A CIR was submitted to the Director related to alleged staff to resident physical abuse toward a resident wherein the resident asked a staff member to leave the room after being woken up by them. The resident proceeded to grab the staff member's arm, and the staff physically abused the resident.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect- Response and Reporting" indicated to "Ensure the safety of and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs and a documented plan to meet those needs."

The resident's clinical records indicated no skin head-to-toe assessments were done immediately after the alleged staff to resident physical abuse incident.

RCM #111 confirmed that the skin head-to-toe assessment was part of the full assessment, and no skin head-to-toe assessment was completed for the resident after the alleged physical abuse.

Failure to assess the resident's skin placed the resident at risk for skin integrity issues.

Sources: CIR, home's "Zero Tolerance of Resident Abuse and Neglect- Response and Reporting" policy, clinical records, interviews with staff. [742649]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A complaint was received by the Director related to a resident's wound care.

The resident returned from the hospital with a wound after having a medical procedure. The licensee's skin and wound program policy directed registered nursing staff to complete a skin assessment on residents at risk for altered skin integrity when there was a change in health status which affected the resident's skin integrity.

The resident's electronic health record indicated a skin and wound evaluation for the resident's wound was not initiated on return from the hospital. The home's wound care lead/ RCM #111 and RPN #110 acknowledged that the above assessment in PointClickCare (PCC) was not initiated. They confirmed that staff were required to use the skin and wound evaluation note when completing the skin and wound assessment, which included taking a picture of the wound.

There was a risk for delayed wound healing when it was not evaluated using the clinically appropriate instrument for skin and wounds.

Sources: Clinical records, home's "Skin and Wound Care Program" policy, and interviews with staff. [741747]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure a resident's altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when an area of altered skin integrity was identified.

Rationale and Summary

A complaint was received by the Director related to concerns with a resident's wound care.

The resident returned from the hospital with a wound after having a medical procedure. The licensee's skin and wound program policy directed registered nursing staff to complete a weekly skin and wound assessment on residents for all types of skin and pressure injuries.

The resident's clinical records indicated the required weekly skin and wound assessments were not completed on multiple days.

The home's wound care lead/ RCM #111 and RPN #110 acknowledged that the above assessment in PCC was not initiated. They confirmed that the nursing staff

were to complete the required skin and wound assessment every week for residents exhibiting altered skin integrity.

There was moderate risk and impact to the resident as the identified wound was not regularly assessed and might have delayed healing and caused infection.

Sources: Clinical records, home's "Skin and Wound Care Program" policy, and interviews with staff. [741747]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that a resident's plan of care for continence was implemented.

Rationale and Summary

A complaint was received by the Director for a resident regarding concerns related to infection prevention, laundry, housekeeping, odors, and the plan of care.

The resident's plan of care specified a toileting program was in place, and team members were to toilet the resident according to assessed needs during specified times.

During interviews with staff on three separate days, it was acknowledged that the toileting program for the resident was not completed, despite it being a part of the plan of care.

By not toileting the resident for their continence care needs, there was a potential risk for discomfort and the development of altered skin integrity.

Sources: Clinical records, interviews with staff. [741751]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

1. The licensee has failed to ensure the needs of a resident with responsive behaviors and that actions are taken to respond to the needs of the resident, including reassessments of interventions and that the resident's responses to interventions are documented.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) for a resident regarding concerns related to IPAC, laundry, housekeeping, odors, and plan of care not being followed.

The resident's clinical records indicated that a program was being implemented for the resident to perform their activities of daily living, to decrease episodes of physical and verbal aggression.

Staff confirmed the home was implementing the program, using a daily checklist to monitor the progress of the resident. Staff stated the resident was not compliant with the activity, and the program was discontinued. Staff were unable to provide information about when the program was discontinued.

RCM #111 confirmed that the program was discontinued, but it remained active on the plan of care. RCM #111 also confirmed that interventions for the resident was not in the plan of care and should be documented by the registered staff whenever there are changes made to the resident's care.

Staff indicated that the program was discontinued, and it should have been reflected on the plan of care. It was also confirmed that no documented assessment and new interventions were put in place to manage episodes of physical and verbal aggression currently.

Failure to assess the resident for responsive behaviours and not placing interventions puts residents at risk for injury and impacts their well-being.

Sources: clinical records, Interviews with staff. [741751]

2. The licensee has failed to ensure actions are taken to respond to the needs of a resident who exhibited responsive behaviors, including the reassessments of interventions and their responses to interventions are documented.

Rationale and Summary

A CIR was submitted to the Director regarding an alleged staff to resident abuse incident. The resident's clinical records indicated that a staff reported to the unit

nurse that the resident made negative comments toward them and hit staff while providing care. The resident's plan of care did not identify any assessments, reassessments, or interventions for behavioural strategies related to verbal and physical aggression.

Staff acknowledged that the resident had responsive behaviours and confirmed that assessments were not completed, and interventions were not put in place to manage them as per home's responsive behaviour policy.

Failure to assess the resident for responsive behaviours and not placing interventions puts residents at risk for injury and impacts their well-being.

Sources: Clinical records, interviews with staff. [742649]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59 (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #010 and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary

A CIR was submitted to the Director, related to an altercation between residents #009 and #010.

A review of the resident #010's progress notes indicated a Dementia Observation System (DOS) was initiated on a specific date, related to a physical altercation towards another resident. The DOS tools implemented to monitor the residents' responsive behaviours were incomplete for many shifts. Staff interviews identified that a DOS monitoring tool should have been initiated and completed by any staff member for five days, or as needed, following a resident-to-resident altercation. Staff indicated the BSO/PSW would evaluate the DOS upon completion and report the findings to the registered staff and BSO lead.

The "Responsive Behaviour Program for Monitoring and Evaluating" policy, directed staff to implement monitoring to help understand the incident and help develop a plan to prevent its recurrence.

RCM #135 acknowledged that DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for residents exhibiting responsive behaviours. The BSO/PSW #125 and RCM #135 confirmed that the DOS documentation was incomplete for multiple shifts.

The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: CIR , BSO DOS worksheets, clinical health records, the Responsive Behaviour Program for Monitoring and Evaluating policy, and interviews with staff. [741747]

2. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #005 and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary

A CIR was submitted to the Director, related to an altercation between residents #005 and #006.

A review of resident #005's progress notes indicated a DOS was initiated on a specific day, for the resident related to a physical altercation towards another resident. The DOS tools implemented to monitor the resident's responsive behaviours were incomplete for many shifts. Staff interviews identified that a DOS monitoring tool should have been initiated and completed by any staff member for five days or as needed following a resident-to-resident altercation. Staff indicated the BSO/PSW would evaluate the DOS upon completion and report the findings to the registered staff and BSO lead.

The "Responsive Behaviour Program for Monitoring and Evaluating" policy directed staff to implement monitoring to help understand the incident and help develop a plan to prevent its recurrence.

RCM #135 acknowledged that DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for a resident exhibiting responsive behaviours. The BSO/PSW #125 and RCM #135 confirmed that the DOS documentation was incomplete for multiple shifts.

The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: CIR, clinical records, "Responsive Behaviour Program for Monitoring and Evaluating" policy, and interviews with staff. [741747]

3. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #006 and other

residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary

A CIR was submitted to the Director, related to an altercation between residents #005 and #006.

A review of resident #006's progress notes indicated a DOS was initiated, for the resident related to a physical altercation towards another resident. The DOS tools implemented to monitor the residents' responsive behaviours were incomplete for many shifts. Staff interviews identified that a DOS monitoring tool should have been initiated and completed by any staff member for five days or as needed following a resident-to-resident altercation. Staff indicated the BSO/PSW would evaluate the DOS upon completion and report the findings to the registered staff and BSO lead.

The "Responsive Behaviour Program for Monitoring and Evaluating" policy directed staff to implement monitoring to help understand the incident and help develop a plan to prevent its recurrence.

RCM #135 acknowledged that DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for a resident exhibiting responsive behaviours. The BSO/PSW #125 and RCM #135 confirmed that the DOS documentation was incomplete for multiple shifts.

The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: CIR, clinical records, "Responsive Behaviour Program for Monitoring and Evaluating" policy, and interviews with staff. [741747]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal, were followed in the IPAC program as required by Additional Requirement 9.1 Additional Precautions (f) under the IPAC Standard.

Rationale and Summary

During an IPAC tour on a confirmed COVID-19 outbreak unit, a staff member was observed in a resident room wearing PPE (Personal Protective Equipment) near a resident on additional precautions. The staff member did not don the appropriate PPE as per the additional precaution signage posted on the resident's door.

The staff member stated they were not required to don the full PPE, because they were not providing direct care to the resident, and only asking them a question.

The home's "Routine and additional precautions" policy indicated before entering a room or bed space or within 2 meters of the resident, on the specified precautions, staff are to clean hands, and wear gown, gloves, and appropriate protection that covers the eyes, mouth, and nose. The IPAC Lead confirmed it was the home's expectation for staff to don the appropriate PPE when entering a resident room on additional precautions.

By conducting improper PPE selection there was a risk of the transmission of infectious agents including COVID-19 to residents and staff.

Sources: Observations, interviews with staff, home's "Routine and Additional Precautions" policy. [000744]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. A member of the nursing management team to educate PSW's #131, #136, and #142 on the home's Zero Lift Policy.
2. A member of the nursing management team to educate all staff working on specific resident home areas on a resident's plan of care related to the resident's transferring and positioning requirements.
3. A member of the nursing management team to educate all staff working on a specific resident home area on a resident's plan of care related to the resident's transferring and positioning requirements.
4. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.
5. Conduct random audits of staff provision of transferring assistance to the residents to ensure safe transferring, including PSW #131, #136 and #142 on all shifts for a period of four weeks.
6. Maintain a record of audits completed, including but not limited to, date of audit,

person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

Grounds

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

Rationale and Summary

A CIR was submitted to the Director indicating a resident had sustained a fall during a transfer resulting in injury.

The home's policy for mechanical lifts and transfers required two qualified team members to always be present when operating lift equipment.

The resident required to be transferred using a mechanical lift by two staff members.

The home's investigation revealed that PSW #131 had left prior to the completion of the mechanical lift transfer. PSW #142 proceeded to transfer the resident to bed alone. During the transfer, the mechanical lift toppled, resulting in the resident falling and subsequently sustained an injury.

The DOC acknowledged that staff did not follow the home's policy, which required a minimum of two team members when operating a mechanical lift.

Failure to transfer the resident utilizing safe transferring techniques placed the resident at risk for injury.

Sources: Clinical records, home's internal investigation notes, CIR, home's "Musculoskeletal Injury Prevention (MIP) and Safe Lift and Transfer Policy and Procedures," and interview with DOC. [741751]

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

Rationale and Summary

A CIR was submitted to the Director concerning an unwitnessed fall of a resident resulting in injury. The resident was subsequently sent to the hospital and then returned to the home with a wound.

The resident's transfers status as documented in their plan of care was two-person assist with an assistive device.

PSW #136 confirmed that they transferred the resident by having the resident stand side by side with two staff, without using the assistive device. PSW #136 further confirmed that they did not reference the resident's plan of care for their transfer status. PSW #136 stated that the resident was to be transferred with an assistive device using a two-person transfer.

The PT confirmed staff were not following the plan of care for the resident related to safe transfer and the resident should remain on the assistive device using a two-person transfer.

Failure to provide the appropriate assistive device as per the care plan during the transfer resulted in the resident’s injury.

Sources: clinical records, interviews with staff. [741751]

This order must be complied with by January 29, 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.