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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: March 19, 2024
Original Report Issue Date: February 28, 2024
Inspection Number: 2024-1710-0001 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Lakeridge Health
Long Term Care Home and City: Lakeridge Gardens, Ajax

Amended By	**Inspector who Amended Digital Signature**
Vernon Abellera (741751)	Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2024.04.11 15:30:51 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
to ensure that the previous issued compliance order that were followed up on this inspection is included in the Licensee report.

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Long Term Care Home and City: Lakeridge Gardens, Ajax	
Lead Inspector Vernon Abellera (741751)	**Additional Inspector(s)** Fatemeh Heydarimoghari (742649) AngieM King (644)
Amended By Vernon Abellera (741751)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
to ensure that the previous issued compliance order that were followed up on this inspection is included in the Licensee report.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30-31, February 1-2, 5-9 and 12, 2024.

The following intake(s) were inspected:

- One Intake related to pain management, bowel and continence care.
- Two Intakes related to a complaint regarding multiple care items.
- One Intake related to physical/emotional abuse.
- Three Intakes related to physical abuse.
- One Intake related to a choking incident.
- Two Intakes related to COVID-19 outbreak.
- Two Intakes related to medication incidents / adverse drug reactions.
- Five Intakes related to falls with injury.
- One Intake related to the First follow-up to Compliance Order (CO) #001 regarding dining and snack service from Inspection #2023-1710-0004, with a Compliance Due Date (CDD) of November 10, 2023.
- One Intake related to the First follow-up to CO #001 from Inspection #2023_1710_0006 related to transferring and positioning technique, with CDD of January 29, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1710-0004 related to O. Reg. 246/22, s. 79 (1) 3. inspected by AngieM King (644)

Order #001 from Inspection #2023-1710-0006 related to O. Reg. 246/22, s. 40 inspected by Vernon Abellera (741751)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg. 246/22, s. 140 (1)

Administration of drugs

140. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a resident's medication incident. Registered staff administered the resident incorrect

medication, which resulted in a transfer to the hospital due to a decreased Level of Consciousness (LOC).

The Registered Practical Nurse (RPN) documented that the resident received the wrong medication, which was prescribed for a different resident. The physician was notified of the error. The physician ordered the resident to initiate the head injury routine (HIR) and complete checks every 15 minutes for the first hour and hourly.

A few hours later, the resident was found lethargic and difficult to arouse and was transferred to the hospital.

The RPN and the Resident Care Manager (RCM) acknowledged that the resident received the wrong medication and was transferred to the hospital due to a medication error.

Failing to administer the prescribed medication to the correct resident negatively affected the resident with a transfer to the hospital.

Sources: CIR, resident clinical records, observations, and interviews with RCM and RPN [742649]

WRITTEN NOTIFICATION: Police notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is 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. O. Reg. 246/22, s. 105, 390 (2).

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

notified of a witnessed incident of physical abuse of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary
A CIR was reported to the Director, for a witnessed abuse by a resident towards to another resident.
The incident occurred when the resident placed a pillow over the other resident's face and positioned the call bell across their neck. The personal support worker (PSW) intervened immediately, and there were no injuries to either resident. There is no record indicating that the police services were contacted.

The RCM confirmed that the police were not called when they became aware of the incident.

Failure to ensure the appropriate police service was notified upon alleged abuse, could potentially increase the risk of recurrence at the home.

Sources: CIR and interview with the RCM. [741751]

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 CIR was reported to the Director for a suspected resident-to-resident physical abuse incident resulting in an injury. The CIR records also indicated no police report was made.

The RCM confirmed the altercation between both residents was a suspected

physical abuse altercation and that no police were called as both residents were immediately separated, and they believed the injury was not severe.

Failure to contact police following an incident of resident-to-resident physical abuse puts the resident at risk of further abuse.

Sources: CIR, residents' progress notes, interview with RCM. [644]

WRITTEN NOTIFICATION: Conditions of licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023-1710-0006 regarding O.Reg. 246/22, s.40 served on December 11, 2023, with a compliance due date of January 29, 2024.

Specifically, the licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
The CO required the home to:

1. A member of the nursing management team to educate specific identified PSW on the home's Zero Lift Policy.
2. A member of the nursing management team to educate all staff working on resident home area five east on the identified 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 resident home area three west on the 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 identified residents to ensure safe transferring, including the identified PSWs 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.

A review of the CO records provided to Inspector #741751 identified the following:

·The home was not able to provide documented education records of the home's zero lift policy for the identified PSWs.
· The home was not able to provide documented education of all staff working on resident home area five east on the identified resident's plan of care related to the resident's transferring and positioning requirements.
· The home was not able to provide documented education of all staff working on resident home area three west on the identified resident's plan of care related to the resident's transferring and positioning requirements.
· The random audits of staff provision of transferring assistance to identified residents to ensure safe transferring, including the identified PSWs on all shifts for a period of four weeks were not completed. The home completed six audits until the end of the CDD. The audit did not identify the shift during the audit or the PSW audited. The compliance order specified auditing two residents, excluding others. Of the six completed audits, four residents were not listed to be audited.

The Director of Care (DOC) acknowledged that they lacked the documentation to support the compliance order issued to the home.

There was potential risk of resident harm due to improper and unsafe resident's transfer when the home failed to provide all staff with the required education on the home's zero lift policy, plan of care related to the resident's transferring and positioning requirements, and safe transfer audits.

Sources: CO #001 from inspection #2023_1710_0006, Compliance Order Binder, Education records, Audits, and interviews with the DOC. [741751]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Conditions of licence

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with CO #001 under O. Reg. 246/22, s. 79 (1) 3. LR# 2023-1710-0004 related to Dining and Snack Service with a compliance due date of November 10, 2023.

Rationale and Summary
The compliance order required the home to:
1. Update the home's pleasurable dining policy to include the PSW/registered staff responsibilities for monitoring residents at mealtimes including for those eating in areas outside of the dining room;
2. For residents requiring tray service to their room the plan of care must provide clear direction if the resident is to be sitting in bed or in a chair and how to be properly positioned;
3. Perform weekly audits during meal service, in all home areas, to ensure residents eating in areas outside the dining rooms are properly positioned and monitored,

according to the home's pleasurable dining policy, for 4 weeks;
4. Keep a documented record of the audit results, dates, times, any corrective actions taken, including names of staff, name of auditor and make immediately available to inspectors upon request.

During this follow up inspection the home failed to provide a documented record of residents eating in areas outside the dining rooms for each resident home area [RHA] for a four-week period. Inspector was unable to verify residents' care plans for revisions and updates providing clear direction to staff if the resident is to be sitting in bed or in a chair and how to be properly positioned and monitored.

Review of the Dining Observation Safe Feeding and Positioning audits provided by the home were incomplete audits. The completed audits for residents requiring tray service of all meal services provided by the home were not completed weekly for four weeks on all RHAs and also did not include the names of the residents' and the staff being audited.

The DOC confirmed that the audits were not conducted as required, staff failed to understand the audit requirements as outlined in the compliance order. Review of the home's records indicated that there was a documented, updated revision to the home's pleasurable dining policy to include the personal support worker [PSW] and registered staff responsibilities for monitoring residents at mealtimes including for those eating in areas outside of the dining room. The home could not produce documentation for residents' eating in areas outside the dining rooms for the four week period, therefore the plan of care for residents could not be verified to provide clear direction if the resident is to be sitting in bed or in a chair and how to be properly positioned.

The DOC provided documentation to support CO #001 which contained the home's

updated pleasurable dining policy to include the PSW/registered staff responsibilities for monitoring residents at mealtimes including for those eating in areas outside of the dining room.

Failure to conduct and document dining audits during meal service, in all home areas, to ensure residents eating in areas outside the dining rooms are properly positioned and monitored puts residents at risk for choking.

Sources: CO#001 Dining documentation and interview with DOC. [644]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.