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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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: April 25, 2024
Inspection Number: 2024-1710-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Lakeridge Health
Long Term Care Home and City: Lakeridge Gardens, Ajax

Lead Inspector	**Inspector Digital Signature**
AngieM King (644)	Angeli M King Digitally signed by Angeli M King Date: 2024.05.06 10:53:14 -04'00'

Additional Inspector(s) Fatemeh Heydarimoghari (742649)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2-5, 8-11, 2024

The following intake(s) were inspected:

- An intake related to Proactive Compliance Inspection - PCI

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management

Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Quality Improvement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Lead was included in the Long-Term Care (LTC) Home's Continuous Quality Improvement (CQI) Committee.

Rationale and Summary
The LTC Home's CQI Committee Meeting minutes dated three months prior to the inspection and home's Quality Council Attendance document listed the attendees. The individuals listed in the attendees did not include a representative from the home's designated IPAC Lead.

The Administrator confirmed that the IPAC Lead was not included in the CQI Committee meetings.

Failing to include the IPAC Lead in the home's CQI Committee risks lacking the IPAC Lead's input and feedback in the home's continuous quality improvement plan and actions.

Sources: Interview with Administrator, LTC home's CQI Committee Meeting minutes home's Quality Council Attendance list. . [644]

WRITTEN NOTIFICATION: Quality Improvement

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee failed to ensure that a pharmacist from the pharmacy service provider was included in the LTC Home's CQI Committee.

Rationale and Summary
The LTC Home's CQI Committee Meeting minutes dated three months prior to the inspection and the home's Quality Council Attendance document listed the attendees. The individuals listed in the attendees did not include a representative from the home's pharmacy provider CareRx .

The Administrator confirmed that the pharmacist from the pharmacy provider,

CareRx was not included in the CQI Committee meetings.

Failing to include the pharmacy representative in the home's CQI Committee risks lacking the pharmacy provider input and feedback in the home's continuous quality improvement plan and actions.

Sources: Interview with Administrator, LTC home's CQI Committee Meeting minutes and home's Quality Council Attendance list. [644]

WRITTEN NOTIFICATION: Quality Improvement

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that a member of the registered nursing staff was included in the LTC Home's CQI Committee.

Rationale and Summary
The LTC Home's CQI Committee Meeting minutes dated three months prior to the inspection and the home's Quality Council Attendance document listed the attendees. The individuals listed in the attendees did not include a representative from the home's registered nursing staff .

The Administrator confirmed that a member of the registered nursing staff was not included in the CQI Committee meetings.

Failing to include a member of the regular nursing staff in the home's CQI Committee risks lacking their input and feedback in the home's continuous quality improvement plan and actions.

Sources: Interview with Administrator, LTC home's CQI Committee Meeting minutes and home's Quality Council Attendance list. [644]

WRITTEN NOTIFICATION: Quality Improvement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that a Personal Support Worker (PSW) was included in the LTC Home's CQI Committee.

Rationale and Summary
The LTC Home's CQI Committee Meeting minutes dated three months prior to the inspection and the home's Quality Council Attendance document listed the attendees. The individuals listed in the attendees did not include a PSW.

The Administrator confirmed that a PSW was not included in the CQI Committee meetings.

Failing to include a PSW in the home's CQI Committee risks lacking the PSW's input and feedback in the home's continuous quality improvement plan and actions.

Sources: Interview with Administrator, LTC home's CQI Committee Meeting minutes and home's Quality Council Attendance list. [644]

WRITTEN NOTIFICATION: Orientation Training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1)
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The licensee failed to ensure all staff who provide direct care to residents was provided annual training in IPAC, abuse and neglect, mandatory reporting, whistleblowing protection, falls prevention and management, skin and wound care, and pain management.

Rationale and Summary
A communication email sent to the inspector from the Clinical Practice Leader (CPL) indicated that in 2022, the Surge online education system was set up with all required orientation and annual refresher education. However, a lack of understanding of the system led to the development of that education, which did not roll over to the following year. As a result, the platform did not notify the staff that annual education was to be completed, and the required education was not captured through the Surge portal.

The CPL confirmed that all staff had not completed the annual, mandatory education in 2023 due to an issue in the Long Term Care (LTC) Home's online education system.

The Director of Care (DOC) confirmed mandatory education was incomplete for 2023; 2022 modules were not rolled over into 2023 to trigger staff to complete all education modules, including the mandatory education in IPAC, prevention of abuse and neglect, whistleblowing protection, mandatory reporting, pain management, falls prevention, skin and wound and residents' rights.

Failing to train direct care staff in fall prevention and management posed a risk to residents' safety and well-being.

Sources: Communication email and interview with the CPL and DOC. [742649]

COMPLIANCE ORDER CO #001 Orientation Training

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

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

1) The Clinical Practice Leader (CPL) to develop an orientation package checklist to include the employee's signature with the date(s) of all mandatory required education completed.
2) The CPL to ensure RPN #100 and PSW #118 completes all mandatory required education of the orientation package checklist.
3) The CPL to keep a documented record of the education content provided to RPN #100 and PSW #118, including the name of the individual who provided the education and the date(s) of the training and make it available to inspectors upon request.
4) The CPL to conduct audits of all staff orientation education completed

for a specific time period to ensure all newly hired staff have completed the required education before they performed their responsibilities. The results of the audits are to be analyzed and corrective actions are to be taken to provide orientation training for the staff identified as having incomplete training. The CPL to maintain a record of the audits completed, including the date(s) of the audit, the person completing the audit, analysis of the audits, and any corrective actions provided. The records are to be made available to inspectors upon request.

5) The CPL to ensure the Surge platform and a tracking method has been developed and implemented for the current year to ensure that all staff are notified to complete all mandatory education annually.

Grounds

The licensee failed to ensure that no person performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

11. Any other areas provided for in the regulations.

Rationale and Summary
During the inspection, the LTCH failed to provide documents to support that RPN #100 and PSW #118 had received orientation training for the Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting, whistleblowing protection and infection prevention and control.

The CPL confirmed that there were no documents indicating that PSW #118 and RPN #100 received orientation training on The Residents' Bill of Rights, the policy to promote zero tolerance of abuse and neglect of residents, mandatory reporting, whistleblowing protection and infection prevention and control.

Failing to provide orientation and training to direct care staff on mandatory requirements listed above posed a risk to residents' safety and well-being.

Sources: Communication via email with home and interview with the CPL. [742649]

This order must be complied with by June 13, 2024

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and

outbreaks. O. Reg. 246/22, s. 102 (10).

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

1) The IPAC Lead to develop and implement a daily infection control surveillance tracking tool to be utilized in all resident home areas (RHA).
2) The IPAC Lead to educate all registered staff on the infection control surveillance tracking tool.
3) Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.
4) The IPAC Lead or Director of Care or a Resident Care Manager(s) to conduct audits once weekly on the infection control surveillance tracking tool for two months on all RHAs to ensure compliance by registered staff.
5) The IPAC Lead or Director of Care or a Resident Care Manager(s) will analyze and monitor any infections in the home on a daily and monthly basis for two months to identify any trends. Document all analysis, trends, corrective actions taken, with the date and the name of the person conducting the analysis. Keep this documentation onsite and readily accessible.
6) The Administrator will review and sign off on the analysis documentation at a minimum of once, weekly basis for two months.
7) Maintain a record of audits completed in all RHAs, including the date of the audit, the RHA, and the person completing the audit, any corrective action taken, and make it available to inspectors upon request.

Grounds

The licensee failed to ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and

outbreaks.

Rationale and Summary
During the inspection, the LTCH was not able to provide any documents to support the home's tracking and analyzing daily and monthly infection symptoms to detect trends and reduce the incidence of infection.

The IPAC Lead and DOC confirmed that the home did not document daily and monthly surveillance data to determine trend analyses.

Failing to ensure that the symptoms indicating the presence of infection in residents are analyzed daily and monthly increases the risk of the spreading of infections.

Sources: Documents provided by home and interview with the IPAC Lead and DOC. [742649]

This order must be complied with by July 31, 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

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.