Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Mar 6, 7, 9, 12, 29, 30, Apr 2, 2012 | 2012_080189_0007 | Complaint |

**Licensee/Titulaire de permis**

TORONTO REHABILITATION INSTITUTE
550 UNIVERSITY AVENUE, TORONTO, ON, M5G-2A2

**Long-Term Care Home/Foyer de soins de longue durée**

LAKESIDE LONG TERM CARE CENTRE
150 DUNN AVENUE, TORONTO, ON, M6K-2R6

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

NICOLE RANGER (189)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Activation Aide, Registered Staff, Personal Support Worker**

**During the course of the inspection, the inspector(s) Reviewed health care records**
**Conducted walk through of resident and common areas**

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

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | WAO – Ordres : travaux et activités |

| | |
|---|---|
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following subsections:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.**
**3. Resident monitoring and internal reporting protocols.**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible;**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and**
**(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. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

Resident was admitted to the home in January 2012 and since admission to the home, resident had several behavioural incidents that required assessments and interventions.

1) Resident was physically aggressive with another resident. Progress notes from Registered Practical Nurse (RPN) states resident entered into resident B room, and while resident B's sitter was trying to assist the resident out of the room, resident hit and splashed a cup of juice over the sitter. Resident also entered into resident C's room and pushed the resident.

2)Progress notes from RPN reports that resident's behaviour remains the same, physically and verbally aggressive towards staff and other residents.

3) Progress notes from RPN reports that while resident was attempting to exit seek, RPN tried to redirect the resident and the resident picked up a plastic cup from the physiotherapist hand and threw onto RPN's forehead, resulting in a large swollen area on the RPN"s head. On that same day, the resident was sitting at the nursing station and was banging the table and told staff to "go away, go away, go through the window" and then proceeded to take a cup of juice and tossed the cup on the Pharmacist, where the Pharmacist clothing and computer got wet.

4) Progress notes from RPN reports while staff entered resident's room for routine check, resident started to yell and shout at the staff and chased the staff to the nursing station.

5) Progress notes from RPN reports that resident's behaviour is inappropriate towards other residents. Resident claimed that another resident took the resident's money and threaten to hit the resident and was verbally abusive.

6) Progress notes from RPN reports that resident was verbally aggressive towards staff and co resident during dinner.

7) Progress notes from RPN reports that resident entered into two resident's rooms and poured water over the residents mouths while the residents were lying in their bed.

8) Personal Support Worker (PSW) reported to the inspector that on the evening of the incident, the resident was found standing at resident D door and the resident's hand's were covered in blood and a bloody activity board was by the door on the floor by resident D room. PSW entered resident D room and resident D was covered in blood and resident D head was bloody. PSW reported the walls and floor was splattered with blood. PSW reported that as the nursing staff was attending to resident D, PSW followed resident to their room and notice that resident had placed the bloody activity board in the garbage in the washroom and was washing the blood off hands.

Inspector spoke with Assistant Director of Care and Director of Care. Resident was not referred to specialized resources prior to the incidents.

There was no assessment for the behaviours noted for resident. There was no interventions implemented, no strategies developed to respond to resident"s behaviours prior to the incidents.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following subsections:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

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**Findings/Faits saillants :**

1. The licensee did not protect resident D from abuse by anyone.

Resident entered into resident D room and repeatedly hit resident D in the head with an activity board. Resident D was sitting in the wheelchair during the incident. Resident D is unable to verbally communicate. PSW informed the inspector that PSW found resident D sitting in the wheelchair with head covered in blood and the walls and floor splattered with blood during the incident.

Inspector reviewed progress notes and interview from staff who reported that resident had multiple aggressive behavioural incidents prior in the home prior to this incident without an assessment conducted or interventions implemented.

Inspector observed multiple red lacerations to resident D face and top of head. Inspector observed two large hematomas under resident D's eyes.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.***

**Issued on this 6th day of June, 2012**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**