Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_631210_0023	012350-19, 016743-19, 018664-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

Lakeshore Lodge
3197 Lakeshore Blvd. West ETOBICOKE ON M8V 3X5

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 16, 17, 21, 22, 23, 24, 25, 2019

The following Critical Incident System (CIS) report intakes were inspected:
- Log #018664-19, #016763-19 and #012350-19, related to falls that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Clinical Nurse Manager, Nurse Managers, Registered Nurses (RNs), Personal Support Workers (PSWs) and Physiotherapist (PT).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to Ministry of Long Term Care

(MLTC) related to an incident that caused an injury to resident #003 for which the resident was taken to hospital on a specified date and which resulted in a significant change in the resident's health status.

A review of resident #003's clinical record indicated the resident had specified diagnoses and a history of falls.

A review of resident #003's written plan of care indicated the resident required total assistance for the activities of daily living (ADL) and transfer with a specific mechanical lift.

Interview with RPN #108 indicated that resident #003 was provided assistance with specified personal care on a specified date. After PSW #107 finished the specified personal care in an area of the unit they transported them to their room. PSW #107 called RPN #108 for help to transfer the resident to their bed. They both transferred the resident using a manual transfer technique and without using the specified mechanical lift.

Interview with PSW #105 indicated that during the morning rounds on a specified date, they found resident #003 in a particular health condition and reported to RN #109. According to RN #109 they assessed the resident and were not able to identify the reason for the condition. Interview with RN #102 and PSW #110 indicated that later in the day the PSW approached the resident to provide personal care. They noticed a swelling on a particular body part. RN #102 assessed the resident and transferred them to hospital for further assessment. The resident was identified with a change in the health status.

Interview with PSW #107 indicated they were aware that resident #003 should be transferred with the specified mechanical lift with two people according to the plan of care, but the mechanical lift was in use, and they decided to transfer them manually. Interview with RPN #108 indicated they were aware about resident #003's transfer status and the requirement to use the specified lift but they helped PSW #107 with a manual transfer of the resident.

During interviews both staff- PSW #107 and RPN #108, acknowledged that on a specified date and time resident #003 was not transferred safely according to the written plan of care.

During an interview, the Nurse Manager (NM) Staff #112 indicated that the home conducted their internal investigation and took appropriate corrective action. NM #112 acknowledged that resident #003 was not safely transferred on a specified date, according to the resident's written plan of care. [s. 36.]

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 make sure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 12th day of November, 2019

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

Original report signed by the inspector.