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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 31, 2023	
Inspection Number: 2023-1594-0006	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Lakeshore Lodge, Etobicoke	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 12, 13, 16, 17, 19, 2023

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00096442, CI #M595-000021-23, related to falls prevention and management.
- Intake: #00097678, CI #M595-000023-23, related to responsive behaviour management

The following intakes were completed in this complaint inspection:

- intake: #00097680 and #00097569, related to responsive behaviours, verbal and alleged sexual abuse

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

Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

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

Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure that the home was a safe and secure environment for resident #001.

Rationale and Summary

A CIS report indicated that resident #001 had a fall on a specified date, sustained injury and was treated in hospital. A private care sitter was in the resident's room during the fall. The resident had two previous falls, with a private care sitter present in their room during both falls.

Resident #001's written plan of care indicated the resident was at risk for falls. They required a specific assistance with personal care.

During the two previous falls, the private care sitter did not follow the resident's written plan of care while assisting them.

On a specified date it was witnessed by the home's staff that the private care sitter did not follow the resident's plan of care when assisting them. No further action was taken by the home.

As per the Nurse Manager (NM) #103, Falls Program Lead #113 and the Director of Care (DOC) #102 the home did not have a process for training private caregivers on providing safe care to residents as per their written plan of care.

Failure of the home to ensure that private care sitters provided safer care to resident #001 placed them at risk for injury.

Sources: observation, review of resident #001's clinical record, home's policy Falls Prevention and Management RC-0518-21, dated Sept 15, 2022, and interviews with Personal Support Workers (PSWs) Registered Nurses (RNs), the Physiotherapist (PT), falls program lead, Nurse Manager (NM) and the Director of Care (DOC).
[210]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that during a specific time period actions were taken to respond to the needs of resident #002 and #004 who demonstrated responsive behaviours, including assessments, reassessments and interventions.

Rationale and Summary

On a specified date, resident #002 presented with responsive behaviours including verbal, and inappropriate sexual behaviours towards another resident. Resident #002 had impaired cognitive status.

On an earlier date, resident #002 touched another resident inappropriately. Staff became aware of this responsive behaviour. There was no referral to the Behaviour Support Ontario (BSO) lead for re-assessment and implementation of interventions to prevent re-occurrence.

Review of the clinical records for both residents and interviews with BSO leads indicated no reassessment of both residents' behaviours and no interventions were in place during a specified time period.

Failure of the home to reassess and initiate interventions related to two residents' responsive behaviors placed the residents at risk of additional incidents and harm.

Source: observations, interview of residents, review of clinical records, and home's policy RC-0517-00 Responsive Behaviour and Management, dated September 15, 2022, interviews with PSW, RN, BSO lead, NM and the DOC.
[210]