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
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Original Public Report

Report Issue Date: September 19, 2024
Inspection Number: 2024-1594-0004
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Lakeshore Lodge, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3 - 6, 9 - 13, and 16 - 17, 2024.

The following intake(s) were inspected:

- Intake: #00116494 / CIS #M595-000007-24 was related to physical restraining.
- Intake: #00119332 / CIS #M595-000009-24 and Intake: #00120109 / CIS #M595-000011-24 were related to abuse.
- Intake: #00119539 was a complainant related to multiple aspects of care.

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

Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there is a written plan of care for a resident that sets out, the planned care of using a specific equipment for the resident.

Rationale and Summary
A Registered Nurse (RN) identified that a resident used a specific equipment to stop other residents from entering the room.

An observation done with the RN after an interview, noted that the equipment was being used for the purpose identified but upon review of the resident's care plan, the RN acknowledged that this planned care was not documented in the care plan.

Two RNs, and a Behaviour Support Ontario (BSO) Lead acknowledged that if this specific equipment was used, the intervention should have been documented in the care plan. After an interview, BSO Lead informed the inspector that the planned care of using equipment was entered in the care plan. Another review of the care plan corroborated that the care plan was updated accordingly.

Failure to have a written plan of care that sets out, the planned care of using equipment did not pose any risk to the health and well-being to the resident, given that the resident still consistently received the care they required.

Sources: Observation, interview with two RNs and BSO Lead; and review of the resident's care plan.

Date Remedy Implemented: September 9, 2024

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect resident #004 from physical abuse by resident #002.

Ontario Regulation 246/22, s. 2 (1) (c) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")".

Rationale and Summary
On a specific date, staff called a nurse and reported that resident #004 was on the floor. It was reported to the nurse that resident #004 fell because resident #002 struck them. Resident #004 was transferred to the hospital.

Director of Care (DOC) substantiated the abuse and stated that resident #002 had struck resident #004, which resulted in resident #004 falling and sustaining an injuring. The DOC, two RNs, and BSO Lead acknowledged that resident #004 was physically abused by resident #002.

Failure to protect resident #004 from physical abuse by resident #002 resulted in injury to resident #004.

Sources: Interview with DOC, RNs, and BSO Lead; review of resident #002 and 004's clinical records.

WRITTEN NOTIFICATION: Protection From Certain Restraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 5.
Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the

home is:
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39.

The licensee has failed to ensure that a resident is not restrained, by the use of locks or other devices or controls, from leaving a room.

Rationale and Summary
On a specific date, Building Services Manager (BSM) noted that an object was used outside the room door, to prevented a resident from exiting the room. The resident was inside the room. BSM brought this to the attention of Registered Practical Nurse (RPN), who immediately removed the object. It was noted that the Personal Support Worker (PSW) had used an object to restraint the resident in the room.

PSW, RPN, Clinical Nurse Manager (CNM) acknowledged that the resident was restrained from leaving the room.

Failure to ensure that the resident was not restrained from leaving their room, placed the resident at risk of sustaining an injury and compromised the staff's ability to monitor the resident and respond to their needs as needed.

Sources: Clinical records review including progress notes of resident, Critical Incident System Report; Interview of PSW, RPN and CNM.