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: September 25, 2023	
Inspection Number: 2023-1594-0005	
Inspection Type: Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Lakeshore Lodge, Etobicoke	
Lead Inspector Cindy Cao (000757)	**Inspector Digital Signature** Cindy Cao Digitally signed by Cindy Cao Date: 2023.09.26 15:57:15 -04'00'
Additional Inspector(s) Kehinde Sangill (741670)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 13 - 15, 18, 19, 2023

The following intake(s) were inspected:

- Intake: #00086783 - M595-000008-23 - related to falls prevention and management.
- Intake: #00088030 - M595-000011-23 - related to responsive behaviours.
- Intake: #00094968 - M595-000020-23 - related to staff to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified.

(i) Rationale and Summary

A resident was at high risk for falls and required the application of an intervention to minimize the risk of fall related injuries.

The resident was observed lying in bed without the intervention on one occasion. This was verified by a Registered Nurse (RN).

A Personal Support Worker (PSW) stated that they removed the intervention before transferring the resident to bed because they thought the resident was uncomfortable. The PSW acknowledged that they did not follow the resident's plan of care when they removed the intervention.

The RN indicated that the resident needed the intervention to mitigate the risk of fall related injuries. The RN acknowledged that the intervention was not applied on the resident as specified in their plan of care.

Failure to ensure the resident was provided with care as set out in their plan of care, placed the resident at risk for a potential injury.

Sources: Observations of the resident; review of resident's clinical records; and interviews with a PSW, a RN and other staff.

[741670]

(ii) Rationale and Summary

A resident had a history of responsive behaviours towards co-residents due to their medical diagnosis. The resident was assigned one-on-one support to monitor their behaviours over a specific time period during the day. This intervention was initiated to ensure residents' safety.

The resident displayed responsive behaviours towards their co-resident on one occasion. A PSW assigned to the resident for one-on-one support admitted that they left the resident unattended to assist with another resident's care when the incident occurred. The PSW acknowledged that they should not have left the resident unattended.

The RN confirmed that one-on-one worker assigned to the resident was not with the resident at the time of the incident. A Nurse Manager verified that one-on-one worker assigned to a resident should be with the resident during the predetermined time period.

Failure to maintain one-on-one support for the resident during the times outlined in their plan of care has placed other residents at risk for harm and injury.

Sources: Resident's clinical records and care plan, interviews with a PSW, a RN and a Nurse Manager.

[000757]

WRITTEN NOTIFICATION: Resident Records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)

The licensee has failed to ensure that a written record was maintained for a resident.

Rationale and Summary

A resident had a history of responsive behaviours towards co-residents due to their medical diagnosis.

The resident displayed responsive behaviours towards a co-resident on one occasion. Resident's clinical records indicated that a clinical monitoring tool was completed after the incident to analyze and evaluate their responsive behaviours patterns. Staff were unable to produce the completed monitoring record for the resident upon request.

The Behavioural Support Ontario (BSO) lead and a RN confirmed that the monitoring record was completed for the resident but they were not able to locate it.

BSO lead and a Nurse Manager verified that the monitoring record was part of the resident's record and should have been maintained. Nurse manager acknowledged that the monitoring record could not be located.

Sources: Resident's clinical records, interviews with a Nurse Manager, the BSO lead and other staff.

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