Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 17, 2021	2021_891649_0011	003837-21, 007242-21, 007610-21	Complaint

Licensee/Titulaire de permis

University Health Network
R. Fraser Elliott Building 1S-417 190 Elizabeth Street Toronto ON M5G 2C4

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 17, 18, 19, 20, 26, 27, 28, 31, June 1, 2, 3, and 4, 2021.

The following complaint intakes were completed during this inspection:
Logs #007242-21 and #007610-21 related to transferring and positioning technique and prevention of abuse and neglect, and
Log #003837-21 related to emergency plans.

PLEASE NOTE: A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 101. (1) 1. was identified in this complaint inspection and has been issued in a concurrent inspection, #2021_892649_0010, dated June 17, 2021.

During the course of the inspection, the inspector(s) spoke with the Interim-Executive Director (I-ED), Director of Care (DOC), Registered Nurse (RN), Physiotherapist (PT), Interim-Dietary Manager (I-DM), Resident Program Manager (RPM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations and interviews, reviewed residents' clinical records, and staffing schedules.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Snack Observation

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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

A complaint was reported to the Ministry of Long-Term Care (MLTC) related to a resident not being offered a beverage on an identified date. A review of the resident's care plan indicated they required a specific intervention. Observation made by Inspectors #649 and #70475, during the afternoon snack pass indicated that the PSW had not gone into the resident's room to offer an afternoon beverage.

The PSW acknowledged that they had not gone into the resident's room to offer an afternoon beverage. They told the inspector they did not feel safe giving anything to the resident for fear of them choking. They further confirmed that they did not have the specific intervention that the resident required on the snack cart at the time of the above mentioned observation. This concern was brought to DOC's attention and they advised that staff should be offering all residents a beverage.

Sources: resident's health records, observations made by Inspectors #649 and #704758, and interview with the PSW and other staff. [s. 71. (3) (b)]

2. As a result of non-compliance identified for the above resident the sample was expanded to another resident.

A review of the resident's care plan indicated they required a specific intervention. Observation made by Inspectors #649 and #704758, during the afternoon snack pass indicated that the PSW had not gone into the resident's room to offer an afternoon beverage.

The PSW acknowledged that they had not gone into the resident's room to offer an afternoon beverage. This concern was brought to DOC's attention and they advised that staff should have offered the resident a beverage and give them the opportunity to refuse.

Sources: resident's health records, observations made by Inspectors #649 and #704758, and interview with the PSW and other staff. [s. 71. (3) (b)]

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 each resident is offered a minimum of, a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

Issued on this 18th day of June, 2021

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

Original report signed by the inspector.