

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 Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

Amended Public Report (A1)

| Report Issue Date | June 6, 2022 | | |
|--|-----------------|---|----------------------------|
| Inspection Number | 2022_1594_0002 | | |
| Inspection Type | | | |
| ☐ Critical Incident Syst | tem ⊠ Complaint | ☐ Follow-Up | ☐ Director Order Follow-up |
| ☐ Proactive Inspection | □ SAO Initiated | | ☐ Post-occupancy |
| ☐ Other | | | _ |
| Licensee City of Toronto | | | |
| Long-Term Care Home and City Lakeshore Lodge, Etobicoke | | | |
| Inspector who Amended Nital Sheth (500) | | Inspector who Amended Digital Signature | |
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INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21-22, 25-28, May 2-4, 2022.

The following intake(s) were inspected:

- Intake #017285-21 related to duty to protect, and maintenance.

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

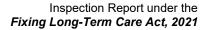
Prevention of Abuse and Neglect

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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.





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NC# 001 remedied pursuant to FLTCA, 2021, s. 154(2)

LTCHA, 2007 s. 6 (7).

The licensee has failed to ensure that the care set out in the plan of care related to dressing was provided to a resident as specified in the plan.

Rationale and Summary

The resident's Substitute Decision Maker (SDM) raised a concern to the Director of Care (DOC), about the resident being inappropriately dressed. According to the resident's plan of care, they required extensive assistance from one staff member for dressing. The staff member to ensure that the resident is dressed appropriately.

Nurse Manager #108 investigated immediately and arranged for a staff member to assist them to get appropriately dressed.

Sources: Copies of emails to the licensee from the resident's SDM, interviews with the SDM, Nurse Manager #104, and other staff.

Date Remedy Implemented: June 4, 2021 [500]