Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Feb 12, 2019	2019_767643_0005	008390-17, 025546-17, 025663-17, 001050-18, 002077-18, 009257-18, 011061-18, 011650-18	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

Lakeshore Lodge
3197 Lakeshore Blvd. West ETOBICOKE ON M8V 3X5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADAM DICKEY (643), CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29-31, February 1 and 5-8, 2019.

The following Critical Incident intakes were inspected during this inspection:
Log #025546-17; CIS #M595-000015-17 - related to suspected abuse,
Log #009257-18; CIS #M595-000011-18, Log #011650-18; CIS M595-000013-18 and Log #011061-18; CIS #M595-000012-18 - related to responsive behaviours,
Log #025663-17; CIS #M595-000016-17 and Log #001050-18; CIS #M595-000001-18 - related to falls prevention and management,
Log #008390-17; CIS #M595-000008-17 - related to suspected improper care, and
Log #002077-18; CIS #M595-000004-18 - related to an unknown injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), clinical nurse manager (CNM), nurse manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN) Registered Physiotherapist (PT), practical care aides (PCA) and residents.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, record review of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A Critical Incident System report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an altercation involving resident #006. Review of the CIS report showed that on an identified date, resident #006 allegedly demonstrated identified responsive behaviours toward resident #005.

Review of resident #006's health records showed they had been admitted to the home with identified medical diagnoses and had a cognitive performance scale (CPS) indicating cognitive impairment. Progress notes showed that on the above mentioned identified date, resident #005 indicated to nursing staff that resident #006 had entered their room, and exhibited identified responsive behaviours toward resident #005. Progress notes showed that resident #006 was started on dementia observational system (DOS) monitoring following the alleged incident.

In interviews, RN #101 and RPN #102 indicated that residents exhibiting new behaviours would be started on DOS to look at trends in behavioural symptoms to identify potential interventions for managing the behaviours. RN #101 and RPN #102 indicated that DOS monitoring would be conducted for five to seven days and be completed by PCA staff on every shift.

Review of DOS monitoring forms for an identified one-week period, showed monitoring of resident #006 began on the above mentioned identified date. No documentation was completed for a seven hour period for four consecutive identified dates, and a 15 hour period on another identified date during the one week period.

In an interview, Behavioural Supports Ontario (BSO) RN #103 indicated that DOS monitoring was used in the home to look at behavioural patterns and identify time of day and type of behaviours residents exhibit. RN #103 indicated that PCA staff would be completing the DOS monitoring form with input from registered staff. Analysis of DOS monitoring documentation would be completed by the BSO team to implement interventions to manage resident behaviour. RN #103 further indicated that all shifts would be expected to complete the monitoring form and additionally discuss the resident's behaviour during shift report, for staff to be aware of resident behaviour. RN

#103 acknowledged that the DOS monitoring form for resident #006 was not fully completed, but indicated it may not have been completed because the resident did not exhibit any behaviour.

In an interview, CNM #112 indicated that if a resident is exhibiting a behaviour DOS monitoring would be initiated to see what behaviours are exhibited and at what time. The DOS monitoring documentation would then be analyzed by BSO RN #103 to identify any behavioural trends to identify and implement strategies to manage the resident behaviour. CNM #112 indicated that the expectation in the home is for DOS monitoring to be completed on all shifts capturing all 24 hours. CNM #103 acknowledged that resident #006's DOS monitoring forms for the above mentioned one-week period were not completed on all shifts as expected. [s. 30. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

This inspection was initiated related to a CIS report submitted to the MOHLTC indicating suspected improper care of a resident.

Record review revealed that on an identified date, resident #002 sustained a specified injury. The records identified that when being assisted by staff with transport to an identified home area using a specified mobility device, the resident was caught in the mobility device and was injured.

According to the resident's plan of care, the resident was severely impaired for decision making, and was totally dependent on staff to assist with locomotion using a specified mobility device.

Interview with the PT, identified that resident #002 could not follow instructions, could not self-transport using the mobility device, and was dependent on staff assistance for transport. The PT identified that resident #002's mobility device should have had identified assistive equipment in use, and they recalled that the assistive equipment was not in use on the mobility device when this incident occurred.

Interview with RN #114, identified that they were the staff who had transported the resident when this injury occurred, and they verified that the assistive equipment was not in place on the mobility device at the time.

Interviews with RN #101 and NM #113, identified that the assistive equipment was not on the resident's mobility device when this incident occurred, and that the resident was not capable of following instructions. RN #101 and NM #113 confirmed that the assistive equipment should have been in place on this resident's mobility device at all times. [s. 36.]

Issued on this 19th day of February, 2019

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

Original report signed by the inspector.