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_0001
Inspection Type
☒ Critical Incident System ☒ 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
Nitalbahen Sheth
2022.06.07 15:50:09 -04'00'

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:

- Complaint intake #006925-22, and
- Critical Incident System (CIS) intake #006085-22 related to duty to protect and skin and wound.

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

- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Residents' Rights and Choices
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

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

WRITTEN NOTIFICATION S. 3 (1) 1

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 3 (1) 1.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted by RPN #110.

Rationale and Summary

The Resident's Substitute Decision Maker (SDM) heard a staff member saying inappropriate words to the resident while providing care. The Resident was exhibiting responsive behaviours while RPN #110 and PSW #111 provided personal care. Both staff members found it challenging to complete the care; meanwhile RPN #110 said inappropriate words to the resident. According to the resident's plan of care, the resident exhibited responsive behaviours, and staff needed to approach them slowly, from the front and minimize background noise. Provide reassurance and emotional support to the resident.

The SDM reported the incident to RN #112 who made changes to the involved staff members assignments, and they were subsequently removed from the resident's care as a result of the home's investigation.

Sources: The resident's progress notes, the home's investigation notes, Critical Incident System (CIS), Interviews with the resident's SDM, RPN #110 and others. [500]