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: May 27, 2024	
Inspection Number: 2024-1594-0002	
Inspection Type: Complaint Critical Incident	
Licensee: City of Toronto	
Long Term Care Home and City: Lakeshore Lodge, Etobicoke	
Lead Inspector Yannis Wong (000707)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 30, 2024 and May 1-3, 6-9, 2024

The following intakes were inspected:

- Intakes: #00104412, #00104414, #00104415, #00104416, #00104418 Complaints related to housekeeping, cleanliness in the home, and infection prevention and control (IPAC)
- Intake: #00104627 [CI: M595-000030-23] - related to a disease outbreak
- Intake: #00105422 [CI: M595-000001-24] - related to a fall resulting in injury

The following intake was completed:

- Intake: #00109067 [CI: M595-000005-24] - related to a fall resulting in injury

The following Inspection Protocols were used during this inspection:

Continence Care
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (d)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

The licensee has failed to ensure that procedures are implemented to ensure that all toilets are maintained.

Rationale and Summary
During observations on May 1 and May 9, 2024, the toilet in a shower room had a paper sign indicating it was out of order.

A Personal Support Worker (PSW) on the unit could not recall when the toilet was last working. A Cleaner Heavy Duty stated they do not clean this toilet and could not recall when it was last working.

The home's procedure for plumbing issues is for staff to submit a work order to inform the Custodian. If the Custodian is unable to fix the issue, they would inform the Building Services Manager and contact a contractor for maintenance. A Custodian stated they were not made aware the toilet was not working and there were no related work orders. The Assistant Administrator (AA) confirmed there was no recent work order to notify the Custodian the toilet was not working. The Director of Nursing (DON) also stated the Joint Health and Safety Committee completed a Workplace Inspection Report of all home areas and that they were unaware the toilet was not working. The DON and AA acknowledged the toilet in the shower room was not maintained.

Failure to ensure a toilet in the shower room was maintained could lead to inability for residents to toilet in a timely manner.

Sources: Observations on May 1 and 9, 2024; interviews with PSW, Cleaner Heavy Duty, Custodian, DON, and AA; home's policy BS-0202-02 "Custodian", last revised January 3, 2016; home's Workspace Inspection Report checklist, HS-0603-02 Appendix C, last revised May 2015. [000707]