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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2017	2017_646618_0022	024767-17	Resident Quality Inspection

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

CECILIA FULTON (618), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 31, November 1, 2 and 3, 2017.

During the course of this inspection the following Critical Incident Intake Log was inspected; M595-000002-17, related to the use of restraints.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

In January 2017, the home submitted a Critical Incident System Report (CIR) reporting an incident that caused an injury and a change in the health condition of Resident #001.

The CIR stated that in January 2017, resident #001 was in his/her room when he/she became restless. Two PCAs assisted the resident with care and sat the resident in their wheelchair. PCA #101 applied an identified Personal Assisstive Device (PASD) for the resident and then left the resident in the room. Shortly after that, staff heard screaming and found resident #001 had moved forward in his/her wheelchair and somehow got an identified body part entangled in the wheelchair, causing an injury to the identified body area.

Review of the written plan of care dated November 2016, revealed specific positioning and PASD directions to be used when resident #001 is up in their wheelchair, for resident safety and comfort.

Interview with PCA #101 revealed that on the date of this incident, he/she was assigned to provide care to resident #001. PCA #101 reported that during the shift, resident #001 required some personal care and following that care, he/she was put in his/her wheelchair by PCA #101 and another PCA. PCA #101 reported providing some of the positioning required and revealed that he/she had not fully engaged the PASD as required.

Interview with RPN #102 revealed that he/she was the registered staff on the date and shift of the incident. RPN #102 revealed that during that shift, he/she heard screaming coming from resident #001's room. RPN #102 revealed that when he/she entered into resident #001 room, he/she found the resident sitting in his/her wheelchair and the wheelchair was not positioned as it should have been and the PASD was not engaged as it should have been and that resident #001 had an identified body part caught in the wheelchair.

Interview with Nurse Manager #100 confirmed that the PASD was not applied correctly, the wheelchair was not positioned properly, and that PCA #101 had not followed the written plan of care for resident #001. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed, and used by residents, staff and visitors at all times.

In November 2017, during stage one of the RQI, the inspector observed resident #004 did not have access to the call bell system when in his/her bed as there was no cord on resident #004's bedside call bell system.

Interview with RN #103 revealed that the call bell cord had been removed by staff on/around February 2017, as the resident was demonstrating an identified behaviour related to the call bell cord. The inspector and RN #103 reviewed resident #004's progress notes and there was no documentation of the resident exhibiting this behaviour.

When asked if resident #004 still demonstrates responsive behaviour, RN #103 reported not as much as before. The inspector and RN #103 reviewed the written plan of care for resident #004, and there was no documentation related to the behaviour in the written plan of care. RN #103 confirmed that the behaviour of removal of the call bell from the wall should have been included in the written plan of care.

Interview with the Acting Director of Care confirmed that resident #004's call bell should be easily seen, and accessible to the resident, staff and visitors at all times and the cord should not have been removed. [s. 17. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every medication incident involving a resident is reported to the resident or the resident's Substitute Decision Maker (SDM).

Review of the home's Medication Incidents for the months of April, May and June 2017, revealed that there had been three medication incidents involving residents in that quarter. Review of the medication incident report forms for resident's #005, 006 and 007 did not include any documentation confirming SDM or resident notification of the incident, and review of resident #005 and 006's progress notes also did not reveal that this notification had occurred.

Resident #007's progress notes were not reviewed, however interview with staff #110, who was the staff involved in the incident revealed that he/she could not recall notifying the resident's SDM of the incident.

Interviews with registered staff revealed that there was uncertainty about who is to make the decision to notify the SDM of a medication error and then who is to do the notifying.

Interview with the ADOC confirmed that all medication incidents involving residents are to be reported to the resident or their SDM and that this notification did not occur for resident's #005, 006 or 007 in the quarter reviewed. [s. 135. (1)]

Issued on this 21st day of November, 2017

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

Original report signed by the inspector.