Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 24, 2021	2021_766500_0017	005062-20, 009086-20, 010297-20, 013549-20, 015564-20, 004218-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street 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

NITAL SHETH (500)

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): June 8, 9, 10, and 11, 2021.

The following intakes were completed during this inspection:

-Log #005062-20, #009086-20, and #010297-20 related to falls resulting in injury
-Log #013549-20 related to breakdown of major telecommunication system,
-Log #015564-20 related to controlled substance, and
-Log #004218-21 related to duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Supervisor Building Services, Supervisor Administrative Services, Manager Residents Services, Nurse Managers (NM), Registered Nursing Staff, and Personal Support Workers.

During the course of inspection, the inspectors observed the residents' care areas; and Infection Prevention and Control (IPAC) practices of the home, and reviewed the residents' and the home's records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to immediately report an allegation of abuse to the Director.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-term care (MLTC) related to allegation of abuse reported by a resident to the home. The CIS report was submitted to the Director, two days later of the home became aware about the incident.

The Nurse Manager (NM) #104 verified that the incident should have been reported immediately to the Director.

Sources: CIS, Progress note, Interviews with NM #104 and other staff.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report submitted to the MLTC related to a fall incident that resulted in injury to the resident for that the resident was transferred to the hospital.

The resident's progress notes indicated that on an identified day, the resident was seen on the floor. The resident complained of pain. The resident was transferred to the bed, pain assessment was completed with, and the resident was administered with as needed (PRN) pain medication which was ineffective. A note documented after four hours indicated that the resident was still verbalizing of pain. There was no pain assessment completed when initial intervention of PRN pain medication was ineffective, and the physician was not called.

Policy on Pain Assessment and Management indicated that if the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

RPN #112, RN #115, NM #104 verified that the resident should have been assessed and physician should have been called when pain medication was ineffective.

Sources: CIS, Progress note, Interviews with RN #115 and NM #104 and others.

Issued on this 24th day of June, 2021

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

Original report signed by the inspector.