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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 19, 2023	
Original Report Issue Date: March 28, 2023	
Inspection Number: 2023-1594-0003 (A1)	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Lakeshore Lodge,Etobicoke	
Amended By Wing-Yee Sun (708239)	**Inspector who Amended Digital Signature** Wing Yee Sun 2023.05.24 09:57:57 -04'00'

AMENDED INSPECTION SUMMARY

The licensee inspection report has been revised to reflect that Compliance Order #001 was rescinded on May 17, 2023, as a result of a Director's Review. The inspection #2023-1594-0003 was completed on February 27-28, March 1-2, 6-8, 2023.

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Amended Public Report (A1)

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Original Report Issue Date: March 28, 2023	
Inspection Number: 2023-1594-0003 (A1)	
Inspection Type: Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Lakeshore Lodge, Etobicoke	
Lead Inspector Wing-Yee Sun (708239)	**Additional Inspector(s)** Christine Francis (740880) Atala Katel (000705) was also present during this inspection.
Amended By Wing-Yee Sun (708239)	**Inspector who Amended Digital Signature** Wing Yee Sun 2023.05.24 09:58:22 -04'00'

AMENDED INSPECTION SUMMARY

The licensee inspection report has been revised to reflect that Compliance Order #001 was rescinded on May 17, 2023, as a result of a Director's Review. The inspection #2023-1594-0003 was completed on February 27-28, March 1-2, 6-8, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 27-28, March 1-2, 6-8, 2023

The following intake(s) were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00003377 - related to injury of unknown cause
- Intake: #00003251 - related to resident-to-resident physical abuse
- Intake: #00004679 - related to injury with significant change in condition
- Intake: #00012116 - related to fall with injury

The following intakes were completed in the CIS inspection:
Intake: #00004129 - related to injury of unknown cause; and
Intake: #00003426, Intake: #00005918, Intake: #00002755, Intake: #00005777, Intake: #00003771 and Intake: #00005427 were related to falls with injury.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the plan of care was revised when a resident's care needs changed.

(i) The resident was observed to be using a specific mobility device. Their care plan indicated to ensure a different mobility device was implemented.

A Personal Support Worker (PSW) acknowledged that based on the resident's ambulation status, the resident no longer required the device specified in the care plan. A Nurse Manager acknowledged that the resident's care plan was not revised and updated when the resident's care needs changed.

The resident's care plan was updated on a specified date to reflect their most current mobility device.

Sources: Observations of the resident, the resident's care plan, and interviews with a PSW and a Nurse Manager.

[740880]

(ii) A referral was sent to the home's Physiotherapist upon the resident's return from hospital. In a progress note by the home's Physiotherapist, a specific fall prevention intervention was recommended to be used. The resident's care plan did not indicate the use of this intervention.

A Nurse Manager acknowledged that the interventions was part of the resident's falls prevention and management interventions, and was implemented, however the resident's care plan was not revised and updated to reflect this.

The resident's care plan was updated later to reflect their most current falls prevention and management interventions.

Sources: The resident's clinical records, and interview with a Nurse Manager.

[740880]

Date Remedy Implemented: February 28, 2023

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
The resident's care plan indicated that they required extensive assistance with transfers, however a transfer device was to be used as needed when the resident was not cooperative. Staff members involved in the resident's transfer on a specified date used a specific transfer method rather than the use of a transfer device.

A Nurse Manager acknowledged that through the home's internal investigation, it was identified that

the resident was improperly transferred by the staff when the resident was not cooperative.

There was a risk of worsening the resident's injury and pain when they were not transferred according to their care plan.

Sources: The resident's care plan, the home's internal investigation notes, and interview with a Nurse Manager.

[740880]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
Registered staff on two specified dates were informed by a PSW that the resident was behaving unusually and there was a change in their weight-bearing abilities; however they did not collaborate in the assessment of the resident.

The home's "Vital Signs" policy, indicated that vital signs shall be monitored as indicated by a change in resident condition, including temperature, pulse rate, respiratory rate, blood pressure, and oxygen saturation. Additionally, the home's "Progress Notes – Intermittent Entry" policy, indicated that an intermittent entry shall be recorded for each identified issue, intervention, or significant change in resident status. The resident's clinical records indicated that there were no vital signs obtained, nor assessments or progress notes completed for the resident on either of the two specified dates until their transfer to hospital.

The resident was later transferred to hospital where they were found to have suffered an injury and required medical intervention.

There was a risk of the resident's injury worsening and delayed treatment when they were not appropriately assessed by the staff.

Sources: The resident's clinical records, the home's internal investigation notes, "Vital Signs" policy, and "Progress Notes – Intermittent Entry" policy, and interview with a Nurse Manager.

[740880]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
On a specified date, one resident was seen by a Registered Nurse (RN) outside of the second resident's room. The second resident pushed the first resident and they fell before staff could intervene. The first resident was transferred to the hospital and sustained an injury.

A Nurse Manager and the Director of Care (DOC) acknowledged that the first resident was physically abused by the second resident.

Sources: Critical Incident (CI) report, clinical records for both residents, written statement from the RN that witnessed the incident, interviews with a Nurse Manager and the DOC.

[708239]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed and the plan of care was revised when the care set out in the plan was not effective.

Rationale and Summary
The resident had an order that allowed them leave the home three times daily.

A RN acknowledged that the resident would go out more frequently than what was ordered. A RN, a Nurse Manager and the DOC acknowledged that the resident would spend most of their time outside.

The DOC acknowledged that the order was not effective and did not reflect the resident's habits.

There was risk that the resident was not assessed for safety based on their increased frequency outdoors.

Sources: The resident's orders and progress notes, interview with a RN, the DOC and other staff.

[708239]

(A1) Appeal/DREV: #174
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Plan of Care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (4) (b)

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.