Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 31, 2017	2017_594624_0014	013424-17	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

Long-Term Care Home/Foyer de soins de longue durée

LAKEVIEW MANOR
133 Main Street P.O. Box 514 Beaverton ON L0K 1A0

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

BAIYE OROCK (624), CRISTINA MONTOYA (461), DENISE BROWN (626)

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): July 26, 27, 28, 31, August 1, 2, 3, and 4, 2017.

The following logs were inspected concurrently:
Log #030115-16, 030194-16, 005692-17, 016188-17, and 016043-17, all related to allegations of resident to resident abuse,
Log #033853-16, 034579-16, 002873-17, and 006273-17, all related to allegations of staff to resident abuse, and Log #007592-17, related to the fall of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the presidents of Residents' and Family Councils, residents, and family members.

A tour of the home was carried out, an observation of medication administration, staff to resident and resident to resident interactions were made. A review was also completed of residents' health records, the Licensee's internal investigations and relevant policies and procedures related to pain management, responsive behaviors, minimizing of restraints, zero tolerance to abuse and neglect, resident personal care, resident intimacy and sexuality, medication incident and adverse drug reactions reporting, and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Related to log #005692-17,

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when, care set out in the plan has not been effective.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director, related to an allegation of resident to resident sexual abuse between residents #025 and #027. Both residents were cognitively impaired.The CIR indicated that the long-term actions to correct the situation and prevent recurrence for both residents included to assess the level of sexual behaviour and risk to determine if interventions were necessary, review with the team for interventions to ensure and support consensual low risk intimacy.

Review of resident #025’s care plan on a specified date, indicated that resident is affectionate towards, and exhibits sexual behaviors directed at staff and residents irrespective of their sex. The behavioral triggers as well as interventions to manage those behaviours were included in the residents plan of care on the specified date, with special attention to be placed on monitoring the interaction between resident #025 and resident #027.

A review of resident #025’s care plan on another specified date, four months after the first specified date, indicated that additional interventions had been added to the resident's care plan. During record review of the resident's progress notes, it was

discovered that there were five incidents of inappropriate sexual behaviors involving residents #025 & #027, on one occasion, and residents #025 and #028 on four separate occasions. The last incident was noted to have occurred a day before additional interventions were added to the resident's care plan.The plan of care for resident #025 was not revised following the incidents that occurred prior.

On a specified date and time, during separate interviews with RPN #133 and RN #134, both indicated that residents #025 and #027 were immediately separated and redirected after the incidents. The RPN and RN considered one of the incidents to be consensual. During an interview with the Resident Care Coordinator (RCC) #116 on the same specified date, the RCC indicated that a capacity assessment was not performed to determine whether the incident was consensual or not.

In reviewing resident #025's health record, there was no indication to support that resident #025 was assessed for capacity at the time of the incidents in order to determine if consent was given or not related to the incidents. The care plan for resident #025 was revised following the fifth incidents of inappropriate sexual behaviors.

The licensee failed to reassess resident #025's sexual behaviours and revise the plan of care of the resident following the incidents repeated inappropriate sexual behaviors over a four month period, when current interventions were not effective.

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 resident is reassessed and the plan of care reviewed and revised related to resident #025's sexual behaviors, when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 :

1. Related to log #005692-17,

The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

In Ontario Reg 79/10, section 2 (1) b, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date and time, a Critical Incident Report (CIR) was submitted to the Director, related to an allegation of resident to resident sexual abuse between residents #025 and #027. As per the CIR, both residents are cognitively impaired. During the record review related to the current CIR, it was identified on a progress note entry that on a separate identified date and time, RPN #133 was informed that resident #025 was engaged in an inappropriate sexual touching behavior with resident #027.

During separate interviews with RPN #133 and RN #134, both indicated that residents were immediately separated and redirected when the incident occured. The RPN and RN considered the incident to be consensual and noted that there was no need to report the incident to the Director. During an interview with RCC #116 on the same day, the RCC indicated that a capacity assessment was not performed to determine whether the incident was consensual or not. The RCC #116 also indicated the incident that occurred between resident #025 and resident #027 met the definition of sexual abuse as noted above and should have been reported to the Director.

The licensee failed to immediately report an incident of suspected sexual abuse involving residents #025 and #027 to the Director.

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 any person who has reasonable grounds to suspect that the abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents' personal items are labelled within forty-eight hours of admission and in the case of acquiring new items.

During the initial tour of the home on July 26, 2017, the following unlabelled personal items were observed in the locations specified:

Shower Room 1131: Dove Damage Solution Conditioner, Cetaphil Body Wash, Dove deodorant, Dove Men Care Dry Spray, Body Butter, Heavenly Vanilla, red comb, purple hair brush with hair in the brush, and a male urinal on the counter.

Tub Room 1113: Daily Control Dandruff Shampoo, Gillette ProGlide Clear Shave Gel, St Ives Spa for Hair Extra Shine Conditioner (Jojoba and Raspberry), Johnson's Shampoo, and Shea Butter Body Wash.

Tub Room 2233: Black brush with hair in the brush which was located on the counter.

Shower Room 2231: Johnson's Baby Powder.

Tub Room 2213: Blue comb and another black comb with hair both found on counter, and a Dove Daily Moisture Hydration Conditioner.

Tub Room 3213: Natural deodorant stick, and Secret deodorant.

Shower Room 3231: Natural deodorant stick.

During an interview on a specified date, PSW #113 identified that the items in tub room 1113 were resident specific personal items and that these items should have been labelled. In separate interviews on another specified date, RPN #126, PSW #127 and PSW #128, all indicated that the personal items of residents should be labelled with each residents' name on admission and on acquisition of new items. On the same specified date, during an interview, RCC #129 indicated that the personal items of residents should be labelled with each resident's name.

The licensee has failed to ensure residents' personal items were labelled.

Issued on this 31st day of August, 2017

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

Original report signed by the inspector.