Ontario

**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 prévue 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**

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 21, 2018 | 2018_414110_0017 | 019581-17, 020903-17, 021328-17 | Critical Incident System |

### 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

DIANE BROWN (110)

### 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): October 31, 2018. November 5, 6, 7, 8, 9, 2018.**

**The following Critical Incident Reports (CIR) and associated logs were inspected:**
**Log #020903-17 and Log #021328-17 related to resident abuse;**
**Log #019581-17 related to the falls prevention program.**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Personal Support Workers (PSW) and Health Care Aides.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to protect residents from abuse by anyone.

A record review of a Critical Incident System (CIS) report and progress notes revealed that on an identified date, PSW #105 observed a resident to resident interaction that would meet the applicable definition of abuse in O. Reg. 79/10 of the Long-Term Care Homes Act.

A record review of resident #002's and #003's written plan of care identified a Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment that revealed both residents were cognitively impaired and both had a Cognitive Performance Scale (CPS) score indicative of moderate impairment.

An interview with PSW #105, who witnessed, intervened and reported the resident interaction confirmed the events as reported. PSW #105 revealed that resident #003 was unable to give verbal consent.

An interview with RN #101 confirmed the events as they were reported by PSW #105. The RN also revealed that resident #003 was cognitively unable to give consent.

A record review and interviews with PSW #105, RPN #102 and RN #101 revealed that resident #002 had not sustained any injury or demonstrate any distress after the incident.

Interviews with RN #101 and RCC #106 confirmed the home failed to protect resident #003 from abuse. [s. 19. (1)]

2. A record review of a Critical Incident System (CIS) report and progress notes revealed that on an identified date, PSW #108 observed a resident to resident interaction that would meet the applicable definition of abuse in O. Reg. 79/10 of the Long-Term Care Homes Act.

A record review of resident #006's written plan of care identified a RAI-MDS assessment that revealed their cognitive skills were severely impaired and a CPS score indicative of moderate impairment.

A record review of resident #005's written plan of care identified a RAI-MDS assessment that revealed their cognitive skill as modified independence and a CPS score indicative of mild impairment.

An interview with PSW #108, who witnessed, intervened and reported the resident

interaction confirmed the events as reported. PSW #108 stated that they felt resident #005 knew what they were doing and was cognitively aware. The PSW revealed that co-resident #006 was cognitively impaired.

An interview with PSW #110 stated that resident #005 was cognitively intact at the time of the incident with resident #006 whereas resident #006 was severely cognitively impaired.

A record review and interviews with PSW #108, #110 and RN #109 revealed that resident #006 had not sustained any injury or demonstrate any distress after the incident.

Interviews with RN #109 and RCC confirmed the home failed to protect resident #006 from abuse. [s. 19. (1)]

***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 all residents are protected from abuse by anyone, to be implemented voluntarily.***

---

**Issued on this 21st day of November, 2018**

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

**Original report signed by the inspector.**