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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: November 16, 2023

Original Report Issue Date: November 8, 2023

Inspection Number: 2023-1563-0003 (A1)

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Regional Municipality of Durham

Long Term Care Home and City: Lakeview Manor, Beaverton

Amended By	**Inspector who Amended Digital Signature**
Holly Wilson (741755)	Holly N Wilson Digitally signed by Holly N Wilson Date: 2023.11.16 14:52:11 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This report was amended at the request of the licensee to amend the Compliance Order #001 with a Compliance Due Date of December 19, 2023, to a Compliance Due Date of January 19, 2024.

Additionally, Compliance Order #001 was amended, Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice. Also, to reflect that this is first time AMP that has been issued to the licensee for failing to comply with this requirement.

The licensee was to proceed with the amendments, as discussed and specific, to Compliance Order #001 as of Friday November 10, 2023.

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Amended Public Report (A1)

Amended Report Issue Date: November 10, 2023	
Original Report Issue Date: November 8, 2023	
Inspection Number: 2023-1563-0003 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Lakeview Manor, Beaverton	
Lead Inspector Holly Wilson (741755)	**Additional Inspector(s)** Miko Hawken (724)
Amended By Holly Wilson (741755)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-19, 23-25, 2023.

The following intake(s) were inspected:

- Intake: #00093803 -First follow-up - Compliance Order (CO) #001 from Inspection #2023_1563_0002, with Compliance Due Date (CDD) September 28, 2023
- Intake related to alleged resident to resident abuse
- Intake related to improper care
- Intake related to resident neglect
- Intake related to a fall
- Intake related to a complaint related to multiple care items

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1563-0002 related to FLTCA, 2021, s. 6 (7) inspected by Miko Hawken (724)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.

The licensee failed to ensure the skin and wound care program must, at a minimum, provided strategies to promote residents comfort and mobility and promote the prevention of infection, including the

monitoring of residents.

Rationale and Summary:

A complaint was received by the Director related to wound care for a resident.

The resident's clinical records indicated they had a fall that resulted in an injury with transfer to the hospital. The resident returned to the Long-Term Care Home (LTCH), but no clinical interventions or assessments were initiated for their injury. Subsequently, the resident had pain and was found to have an alteration in skin integrity.

The LTCH's Skin and Wound Care Program did not include strategies for skin and wound interventions following an injury.

The Skin and Wound Care Lead and Resident Care Coordinator (RCC) stated that the Skin and Wound Care Program failed to include skin and wound interventions and related assessments specifically for this type of injury.

If skin and wound assessments were included in the LTCH's Skin and Wound Care Program, this could have reduced or prevented the alteration and diagnosis of the altered skin integrity.

Sources: Complaint to the Director, resident's clinical records, Policy, last revised May 2023. and interviews with staff. [724]

WRITTEN NOTIFICATION: When Reassessment, Revision is Required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was reassessed, and the plan of care was reviewed and revised as the resident's care needs changed.

Rationale and Summary:

A complaint was received by the Director related to a resident's skin and wound care. A resident's clinical records indicated they had a fall that resulted an injury with transfer to the hospital. The resident returned to the Long-Term Care Home (LTCH), but no clinical interventions or assessments were initiated for their injury.

The Skin and Wound Care Lead and the RCC indicated that assessments should have been initiated by registered staff to complete at the time that the resident returned from the hospital.

By failing to ensure the resident's interventions were updated when their needs changed resulted in their needs not being met.

Sources: Complaint to the Director, resident clinical records, and interviews with staff. [724]

WRITTEN NOTIFICATION: Transferring and positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary:

A Critical Incident (CI) was reported to the Director regarding incompetent treatment to a resident. A Personal Support Worker (PSW) took a resident to the tub room for a bath and proceeded to use a mechanical lift by themselves to transfer the resident. This was reported to registered staff.

The home's policy indicated that when using a mechanical lift on a resident, the mechanical lift, is to be operated by a minimum of two trained resident care providers to lift, transfer or reposition a resident.

The PSW and the Registered Nurse (RN) confirmed that the resident was transferred out of the tub without a second trained staff to operate the lift.

Failure to lift and transfer a resident using a mechanical lift device with two trained staff, placed the resident at risk of injury.

Sources: CI, Policy (last reviewed February 23, 2022), Interviews with staff. [741755]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee failed to ensure that, for a resident who demonstrated responsive behaviors, actions are taken to respond to the needs of the resident including reassessments and interventions, and that their responses to interventions are documented.

Rationale and Summary:

A CI was submitted to the Director related to an allegation of abuse by a resident to another resident. A resident grasped another resident's right arm, where they sustained a skin injury. Neither resident had recollection of the incident, and both had cognitive impairment.

The home's Responsive Behavior policy directed the interdisciplinary team to develop the plan of care and resident specific strategies to prevent and manage responsive behaviors and will be communicated to all staff providing care.

A Dementia Observation System (DOS) was initiated after the incident, and the resident exhibited responsive behaviors on several occasions. The Behavioural Support Ontario (BSO) team did not reassess the resident or implement appropriate interventions.

The resident's clinical record identified that they had several documented instances of behaviors with Gentle Persuasive Approach (GPA) being used and was ineffective. The resident's plan of care did not indicate any focus and interventions related to responsive behaviors.

The BSO RPN confirmed that the resident exhibited behaviors prior to the critical incident, during the DOS observation period, and was incorrect in their assessment of the resident. The BSO RPN also confirmed that they did not do a thorough assessment of the DOS, progress notes, and did not update the care plan to reflect any interventions or assessments during the DOS period. The DOC confirmed the same.

Failure to identify and implement interventions for a resident resulted in an altercation towards another resident resulting in a skin injury.

Sources: CI, resident's health records, Policy, revised November 2022, and interviews with staff. [741755]

COMPLIANCE ORDER CO #001: Plan of Care

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate all care staff Registered Nurses, Registered Practical Nurse, Personal Support Workers on the use of all fall's prevention interventions with the importance of ensuring residents who are required to have falls prevention interventions have them applied and are in place.
2. Following the completion of training, all care staff, as noted in #1, are to complete an evaluation of learning through the use of a written test that is to be completed independently without any aids. A satisfactory grade for the completion of this training will be no lower than 85 percent (%). Keep a documented record of the written test and evaluation of learning including the names of the individual who completed the test, the individual who administered the test, the dates of the test, the scores of the test, and the content of the evaluation/written test.
3. The DOC or management designate will review and analyze the plan of care for all residents on a Resident Home Area and determine all residents that require the use of falls prevention interventions.
4. The DOC or management designate will conduct daily audits on a Resident Home Area for a two-week period, on days and evenings shifts to verify that the identified residents have their falls prevention interventions in place as per their plan of care. This will be followed with checks, completed by the DOC or management designate, to complete audits three days per week, on days and evenings shifts for a further two weeks.
5. The DOC or management designate who identifies residents that do not have falls prevention interventions in place as indicated in the resident's plan of care, will require corrective action of further education or discipline of the care staff involved.

Grounds

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to falls.

Rationale and Summary:

A written complaint was received by the Director related to falls prevention interventions of a resident.

A Critical Incident (CI) was also submitted to the Director related to the fall. The CI indicated resident was walking and fell. The resident complained of pain and was subsequently transferred to hospital for further assessment where they were diagnosed with an injury.

The plan of care for resident indicated that that staff were to provide falls interventions and ensure that they were in place due to the risk of falls.

The Long Term Care Home (LTCH) 's investigation notes indicated that at the time of the fall, the falls interventions were not in place.

Staff confirmed that at the time of the fall, the resident did not have their falls intervention in place per their plan of care.

Failing to ensure that falls interventions were in place to the resident, as specified in the plan of care, could have reduced the risk of injury.

Sources: Complaint letter, CI, Resident's health record, LTCH investigation Notes and interviews with staff. [724]

This order must be complied with by

January 19, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001:

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

1. s. 6 (7) - for not following plan of care not being followed related to a fall
2. s. 6 (7) - for not following plan of care

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.