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

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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
Apr 24, 2019	2019_784747_0007	014858-18, 014946-18, 019272-18, 020952-18, 023855-18, 005524-19	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

LAURIE MORRISON (747)

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): April 1, 2, 3, 4, 5, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intakes related to falls had been inspected:

-Log #005524-19
-Log #020952-18
-Log #023855-18
-Log #014858-18
-Log #019272-18
-Log #014946-18

During the course of the inspection, the inspector reviewed resident clinical health records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Health Care Aides (HCA), Personal Support Workers (PSW), Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the Resident Care Coordinator (RCC)

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan.

The home had submitted a Critical Incident System (CIS) report to the Director on an identified day, for an incident that caused an injury to a resident which resulted in a significant change in the resident's health status. Resident #001 had an incident occur where the registered staff assessed and provided care to the resident.

A review of resident #001's written plan of care with an identified review date, indicated they had an identified diagnosis which resulted in the requirement of the total assistance of two staff members for the completion of their Activities of Daily Living (ADL's).

A review of resident #001's weekly skin assessments, on identified dates, indicated they had a skin integrity issue.

A review of resident #001's progress notes for an identified time period revealed resident #001 was noted to be experiencing increased pain with movement and positioning required for completion of their ADL's and treatments, and different methods of pain management were being trialed. It was further revealed that there was increased localized pain and swelling noted to an identified area. On an identified day the Nurse Practitioner (NP) assessed the resident and ordered an identified assessment. On an identified day, resident #001's results were received by the staff, which showed a significant change to their health status.

An interview with Registered Practical Nurse (RPN) #109 indicated they had worked on an identified day, and was assigned to resident #001's care. The RPN stated they went to the resident's room, at an identified time, to carry out a treatment. RPN #109 indicated they provided the treatment to the resident on their own without the assistance of another staff member. While completing the treatment an identified incident occurred, requiring assessment and increased staff assistance. RPN #109 acknowledged resident #001 required total assistance from two staff for all aspects of their care and in this case, care had not been provided to resident #001 as specified in the plan of care.

Separate interviews held with Personal Support Worker (PSW) #110, and Health Care Aides (HCA) #100 and #111, all indicated that resident #001 required two staff assistance for identified aspects of care. It was also indicated during these interviews that the registered staff would inform the PSW and HCA's of when the treatment was going to be completed so that the resident could be positioned prior to the registered staff entering the room.

During an interview with Resident Care Coordinator (RCC) #108, resident #001's written plan of care had been reviewed with the inspector and the RCC acknowledged that two staff were to provide assistance to resident #001 for completion of their ADL's. The RCC further indicated that the home's expectation was for all staff to follow the written plan of care when providing care to resident #001. The RCC indicated the home's investigation of the incident was inconclusive in determining the cause of the significant change to resident #001's health status, as the resident's predisposing medical diagnosis may have contributed to this unexpected change.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 10th day of May, 2019

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

Original report signed by the inspector.