Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 9, 2020	2020_595110_0006	024172-19, 024321-19	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

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): February 25, 26, 2020. March 2, 3, 4, 2020.

Two Critical Incident Reports (CIR) both related to a resident fall with injury were inspected.

During the course of the inspection, the inspector reviewed the staff schedules, resident clinical health records and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Acting Administrator, Manager of Nursing Practice, Registered Nurse, Registered Practical Nurse, Physiotherapist, Personal Support Workers.

**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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

This Inspection Protocol (IP) was initiated related to a Critical Incident Report submitted to the Ministry of Long Term Care documenting that resident #001 had a fall that resulted in a significant change in their health status.

A review of the resident's written plan of care for 'Toileting' and 'Bladder Function', 'Risk of Falls' and 'Mobility' was completed.

An interview with PSW #100, #101 and PRN #102 described the resident and interventions to meet their Toileting' and 'Bladder Function', 'Risk of Falls' and 'Mobility' needs. The needs of the resident were was not provided as clear direction in the resident's plan of care.

An interview with the Manager of Nursing Practice and Acting Administrator confirmed the plan of care did not set out clear directions to staff and others who provide direct care to the resident related to the resident's toileting, mobility and risk of falls care needs. [s. 6. (1) (c)]

2. This Inspection Protocol (IP) was initiated related to a Critical Incident Report submitted to the Ministry of Long Term Care documenting that resident #002 had a fall that resulted in a significant change in the resident's health status.

A review of the resident's written plan of care for 'Toileting' and 'Bladder Function', and 'Risk of Falls' was completed.

An interview with PSW #109 stated the resident had a toileting plan and described the plan. An interview with PSW #110 shared they would toilet the resident and described a different routine. .

An interview with PSW #11 stated the resident would be toileted on a different schedule.

An interview with RPN #113 revealed that care plans were generic and lacked direction for staff on the resident's toileting routine.

A review of the resident's written plan of care for 'Risk of Falls" stated to ensure resident uses assistive devices (specify: cane, walker, raised toilet seat, high low bed etc). The plan failed to be customized and provide clear directions of the resident's required assistive devices.

An interview with the Manager of Nursing Practice and Administrator confirmed the plan of care did not set out clear directions to staff and others who provide direct care to the resident related to the resident's toileting and risk of falls care needs. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This Inspection Protocol (IP) was initiated related to a Critical Incident Report submitted to the Ministry of Long Term Care stating that resident #001 had a fall that resulted in a significant change in their health status.

An interview with RN #105 stated that registered staff update the resident's plan of care quarterly or as needed.

A review of the Risk of Falls' plan of care, identified interventions such as educating the

resident on correct transfer techniques; ensuring the resident is aware how to use bed height controls and to reinfoce to resident the need to call for assistance.

An interview with PSW #100 revealed the resident was very confused, unable to communicate their needs and was unable to use a call bell.

An interview with PSW #101 shared that resident #001 was confused and unable to take direction.

An interview with RN #105 stated the interventions noted above were not applicable to resident #001 and the plan of care had not been revised as this care set out was no longer necessary.

An interview with the Manager of Nursing Practice and Administrator confirmed the resident's plan was no longer necessary and had not been revised. [s. 6. (10) (b)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 25th day of March, 2020

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

Original report signed by the inspector.