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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 13, 2022	2022_941746_0001	010411-21, 014243-21, 014244-21	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

AMANDEEP BHELA (746), ERIC TANG (529)

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): January 4-7, 2022.

Two logs related to a follow-up inspection of Compliance Order #001 and Compliance Order #002 from inspection #2021_595110_0009 with a compliance due date of October 29, 2021, related to falls.
One log related to falls

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Nursing Practice Manager, Physiotherapist (PT, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aides (HCA) and residents.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, reviewed clinical health records, internal investigation notes, staff schedules, and discussed relevant home policies and procedures.

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

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_595110_0009	746
O.Reg 79/10 s. 8. (1)	CO #002	2021_595110_0009	746

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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that a falls prevention intervention was in place to prevent injury from falls when resident #005 was in bed as specified in the plan of care.

A review of resident #005's care plan indicated that a falls prevention intervention was to be in place to prevent injury from falls when resident was in bed.

An observation was made with RPN #108, in resident #005's room. Resident #005 was sleeping on their bed, and the falls prevention intervention was not in place. RPN #108 acknowledged the observation and applied the intervention. Interview with RPN #108 confirmed that the intervention was not applied when resident #005 was in bed and should have been applied as per resident #005's care plan.

Interview with the Acting Director of Care confirmed that the purpose of the falls prevention intervention was to decrease the risk of fall injury and should have been in place for resident #005 when in bed.

Sources: Resident #005 plan of care, resident #005 observations, and staff interviews (RPN #108 and the Acting Director of Care). [s. 6. (7)]

2. The licensee failed to ensure that staff who provided care to resident #003 were kept aware of the contents of the plan of care.

A review of resident #003's plan of care indicated that the resident was to have a falls prevention intervention applied when in mobility device.

An observation in resident #003's room was conducted, where the resident was observed to be seated in their mobility device, with the intervention not applied. RPN #109 was asked about this intervention, they indicated that the resident does not require this falls prevention intervention. A review of the resident's plan of care was conducted with the RPN, who acknowledged that the falls prevention intervention does need to be applied to the resident when they are in their mobility device, they further indicated that they were not aware of this intervention. An interview with HCA #101 further indicated that they were also not aware that the resident required the identified falls prevention intervention when in mobility device.

Nursing Practice Manager #107 acknowledged that staff failing to be aware of resident #003's fall intervention, when in mobility device may delay staff response to an actual or potential fall.

Sources: Observations, resident #003's plan of care, interview with HCA #101, RPN #109 and Nursing Practice Manager #107. [s. 6. (8)]

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 residents, to be implemented voluntarily.

Issued on this 14th day of January, 2022

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

Original report signed by the inspector.