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

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Public Report

Report Issue Date: February 20, 2025
Inspection Number: 2025-1563-0002
Inspection Type: Critical Incident Follow up
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Lakeview Manor, Beaverton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10, 11, 12, 19, 20, 2025
The inspection occurred offsite on the following date(s): February 13, 14, 2025

The following intake(s) were inspected:

- An intake related to abuse
- An intake related to an Outbreak
- An intake related to a Second Follow-up from inspection #2024_1563_0003, CO #001 related to O. Reg. 246/22 - s. 20 (e) - Communication and response system, compliance due date of November 29, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1563-0003 related to O. Reg. 246/22, s. 20 (e)

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately report an outbreak to the Director.

The Infection Control Practitioner (ICP) confirmed that a Critical Incident report (CIR) was submitted to the Director two days after an outbreak involving two resident home areas was declared on a specified date by the local Public Health unit (PHU).

Sources: CIR, PHU Outbreak Measures confirmation email, resident line listing, and interview with ICP.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (2)

Reports re critical incidents

s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to immediately report an outbreak to the Director under subsection (1) and it is after normal business hours utilizing the Ministry's method for after hours emergency contact.

The ICP confirmed that a CIR was submitted to the Director two days after an outbreak involving two resident home areas was declared on a specified date by the local PHU, also that the Ministry's method for after hours emergency contact was not utilized.

Sources: CIR, PHU Outbreak Measures confirmation email, resident line listing, and interview with ICP.

WRITTEN NOTIFICATION: CMOH AND MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.
In accordance with the Minister's Directive: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings indicates weekly Infection Prevention and Control (IPAC) audits should be conducted for the duration of the outbreak.

A CIR was submitted to the Director for an outbreak declared by the local PHU on a specified date. IPAC self-audits were not completed for two weeks during the duration of the outbreak. The ICP verified that that IPAC Audits were not completed as required.

Sources: CIR, IPAC self-audits, Public Health OB Measures confirmation email, Minister's Directive: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings and interview with the ICP.

NOTICE OF RE-INSPECTION Fee Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Follow-up #2 - CO #001 / 2024_1563_0003, O. Reg. 246/22 - s. 20 (e) - Communication and response system, CDD 11/29/2024

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.