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

Public Report

Report Issue Date: July 2, 2025

Inspection Number: 2025-1563-0004

Inspection Type:
Critical Incident

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): June 4, 5, 9, 10, 16 to 20, and July 2, 2025.

The following intake(s) were inspected:

- Intake: #00144767 - related to a resident fall with injury.
- Intake: #00147160 - related to resident to resident physical abuse.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, as specified in the plan, when a multi-disciplinary risk meeting indicated the plan was to continue with regularly scheduled checks for the resident, due to an altercation with a co-resident. A registered practical nurse (RPN) confirmed that staff were unaware that the regularly scheduled checks were to be completed. The Resident Care Coordinator (RCC) confirmed that checks were to be performed to monitor the resident's location and safety as it related to co-residents, and this should have been in the care plan and it was not.

Sources: observed conversation between RCC and RPN, resident clinical records, RCC interview.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Monitoring of all residents during meals.

The licensee failed to ensure that the dining and snack service included monitoring

of all residents during meals, when a registered nurse (RN) documented that they were informed by the healthcare aides (HCAs) that a resident was slow with their food, refusing assistance, and wanted to be left to finish their meal. The RN confirmed that the resident had been left alone to finish their meal on a specified date. The resident's care plan directed staff to provide supervision, including oversight/encouragement/cueing, without physical assistance to eat/drink.

Sources: resident clinical records, RN interview.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to Infection Prevention and Control (IPAC), in accordance with Section 9.1 under the IPAC Standard for Long-Term Care Homes (Sept 2023), when at minimum, Additional Precautions shall include: f) Additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Two personal support workers (PSWs) were observed entering a resident's room, without putting on personal protective equipment (PPE), while the resident was sitting just inside the doorway. A PPE supply caddy was hanging from the resident's room door and an additional precautions sign was also posted. A registered

practical nurse (RPN) confirmed that PPE was needed to protect the resident from potential exposure to the respiratory outbreak.

Sources: PSW observation, RPN interview.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection were recorded for a resident, after their return from hospital on a specified date. A registered practical nurse (RPN) had documented that the resident was placed on additional precautions due to a specific infectious process, however the Infection Control Practitioner (ICP) was unable to recall any discussions/assessments related to the precautions, and no further documentation was found in the electronic record. The ICP confirmed that staff should be documenting in the progress notes when symptoms resolve and additional precautions are discontinued.

Sources: resident clinical record, ICP interview.

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