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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2014	2014_195166_0017	O-000447-14	Resident Quality Inspection

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

CAROLINE TOMPKINS (166), ANANDRAJ NATARAJAN (573), MARIA FRANCIS-ALLEN (552), PATRICIA BELL (571)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 9, 10, 11, 12, 13, 16, 17,18, 19, 2014

Critical Incident Logs# O-00154-13, O-001182-13, O-000173-14, O-000226-14, O-000500-14 and Complaint Log #O-000496-14 were inspected concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, Personal Support Workers, Health Care Aides, Housekeeping Aide, Dietary Aide, Registered Nurses, Registered Practical Nurses, Administrator, Assistant Administrator, Director of Care, Resident Care Coordinator, Environmental Service Manager, Social Worker, President of the Residents' Council, President of the Family Council, Nursing Practice Leader.

During the course of the inspection, the inspector(s) Observed staff to resident interactions, recreation/program activities, meals and snack services, observed residents' environment, including individual resident rooms and common areas. Observed medication administration and infection practices. Reviewed residents' clinical records, the licensee's documentation related to specific investigations. Reviewed the licensee's policy related to Abuse and Neglect-Prevention, Reporting and Investigation, Falls Prevention and Management Program, Reporting and Complaints, Medication Administration Program, Drug Destruction and Disposal, Self Administration of Medication, High Alert Medications, Antibiotic Resistant Organism Surveillance and Management, Administration of Topical Medications by a Health Care Aide or Personal Support Worker, Lifts and Transfer, Environmental Services and Tuberculosis Screening.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Log # O-000226-14:
Critical Incident #M546-00005-14 was received indicating that Resident #002 had reported to Registered staff #130 that they had been abused by Staff #132.
Review of the clinical documentation and the critical incident report submitted indicated that the resident is cognitive well but was unable to remember the exact day and time of incident.
In the critical incident report documentation, Resident #002 indicated that Staff #132, while providing care to the resident used excessive force causing the resident to call out with pain.
Review of the licensee's record of the investigation, including hand written accounts of the event, interview notes of the staff involved, interview notes from the resident and interview with the Resident Care Coordinator indicated the following:
Staff #133 was present during the alleged incident of abuse heard the resident call out and witnessed Staff #132 move the resident abruptly..
Staff #133 did not report the incident of physical abuse of a resident.
The day following the incident, Staff #131 was informed of the of physical abuse by Resident #002.
Staff #131 did not report the incident of physical abuse.
Resident #002 informed Staff #130 that Staff #132 had hurt the resident during care and had caused pain to the resident.
Staff #130, notified a manager of the incident via email. The manager was not available and did not receive the information when the incident had occurred.
Five days after the allegations of physical abuse of resident by a staff, the incident was reported the to the licensee.
The licensee notified the Director of the allegations of physical abuse immediately after being made aware of the incident.
Resident #002 was interviewed during this inspection and indicated they could not recall the details of the incident.
The licensee failed to ensure a person who has reasonable grounds to suspect that abuse of a resident by the licensee or staff that resulted in harm or risk of harm to a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

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 every person, including all staff members from all departments, registered and non registered staff are aware of their obligation under this legislation to immediately report the suspicion of abuse of resident by anyone that resulted in harm or risk of harm to the resident and the information upon which it   based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Log O-000173-14
The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of physical abuse of a resident that the licensee suspects may constitute a criminal offence.
The licensee was informed that Staff #122 was observed rough handling the mechanical lift, causing Resident #4205 to swing unsafely, then Staff #122 was observed providing personal care to Resident #4205 with excessive force causing the resident to verbalize pain and comment that Staff #122 had hurt the resident.
Review of the licensee's documentation and interview with the Director of Care indicated that the appropriate police force was not notified of any alleged, suspected, or witnessed incident of physical abuse of a resident.

Log O-000226-14:
Critical Incident #M546-000015-14 was received, reporting that a witnessed incident of alleged physical abuse had occurred.
Staff #132 allegedly used excessive physical force during care causing Resident #002 to report that Staff #132 had hurt the resident, causing pain to the resident.
Review of clinical documentation and interview with the Resident Care Coordinator indicated that the appropriate police force was not notified of any alleged, suspected, or witnessed incident of physical abuse of a resident. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

Log-000173-14
Critical Incident #M546-000002-14 was submitted reporting an incident of improper treatment of a resident.
Review of clinical documentation, the licensee's investigation and interviews with the Director of Care indicated that Staff #135 had transported Resident#4148 through public areas within the resident's home area, while the resident was not appropriately covered or dressed.
Resident #4148 was interviewed during this inspection and indicated they could not recall the details of the incident.
The licensee failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. [s. 3. (1) 1.]

WN #4: 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. (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 :

Log O-001182-13
The licensee has failed to comply with LTCHA, 2007 S.O.2007, c.8, s.6 (7) in that the licensee specifically failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
Critical Incident #M546-000050-13 was submitted indicating that Staff #104 and Staff #109 had reported to the home witnessing Staff #122 providing continence care to #003's and Resident #4205's while the residents were in a transfer sling suspended from a mechanical lift over their wheelchairs.
Resident #003's plan of care related to toileting and hygiene directs staff to:
- personal hygiene, 2 staff total assist
-toileting-total dependence-2 staff to provide total assistance.
Resident #4205 plan of care related to toileting and hygiene directs staff to:
-toileting-total dependence-2 staff to provide total assistance.
Resident #4205's and Resident #003's plan of care does indicate toileting hygiene is provided to either resident while the resident are in a transfer sling suspended above their wheelchairs.
The licensee failed to ensure the care set out in the plan of care for Resident #003 and Resident 4205 was provided as specified. [s. 6. (7)]

Log O-000173-14
Critical Incident # M546-000002-14 was submitted indicating that an incident of improper transfer for Resident #4148 had occurred.
The critical incident indicated that Resident #4148 had reported to the Resident Care Coordinator that Staff #135 transferred Resident #4148 to bed using a tub lift chair, unassisted.
Review of the licensee's investigation indicated the home's policy related to lifts and transfers ,HRD-02-02-15 states "Never use tub chair as a means of transportation for residents. Two or more trained personnel must be participating during the lift".
Review of the Resident #4148's plan of care related to transfers, directs staff to use a mechanical lift and 2 staff to assist.
The licensee failed to ensure the care set out in the plan of care for Resident #4148 was provided as specified. [s. 6. (7)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.
June 10, 2014, it was observed that the licensee's main exit door was able to be opened by sliding the door by hand, even though it appeared to be locked.
This was immediately reported to the Environmental Service Manager. A door/mag lock company was at the home and assessing and repairing the locking mechanism on June 10/14.
While the door lock mechanism was being repaired the home was monitoring the door using an audible alarm which notified staff immediately if the front exit door had been opened. The alarm could only be cancelled at the point of activation.
Discussion with the Environmental Services Manager indicated all exit doors are regularly checked.
June 11, 2014, the main front door was observed to be repaired and the locking mechanism functioning correctly. [s. 9. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Log O-0001182-13
The licensee failed to ensure that the resident and the resident's substitute decision-maker (SDM), if any, are notified of the results of an investigation related to an alleged, suspected or witnessed incident of physical abuse of a resident immediately upon completion of the investigation.
The licensee was informed that Staff #122 was observed rough handling the mechanical lift, causing the resident to swing unsafely. Staff #122 was then observed to use excessive force when providing personal care causing the resident to verbalize that Staff #122 had hurt the resident.
Review of the licensee's investigation documentation and interview with the Director of Care and the Resident Care Coordinator indicated Resident #4205's SDM was not notified of the results of the alleged physical abuse investigation immediately upon the completion. [s. 97. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 110. (1) 1 in that the home did not applied a physical device in accordance with the manufacturer's instruction.

During this inspection, Resident #4196 was observed seated in a tilt wheel chair with a lap tray and a front closing lap belt that was loose as evidenced by greater than 5 finger width gap between the Resident's waist and the lap belt.
When Resident #4196 was asked to undo the lap belt, the resident was unable to undo the lap belt.
Registered staff #123, examined the resident's front closing lap belt and indicated that it was too loose. Registered staff #123 and Personal Support Worker staff #124 readjusted the resident's front closing lap belt to fit the resident properly.Interview with Registered staff #124 indicated that a referral to the Occupational Therapist would be made to assess the seat belt for the resident. [s. 110. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Review of the licensee's policy Policy 5-4 Drug Destruction and Disposal, section #5:
-On a routine basis (monthly at a minimum), medications for destruction are transferred from the separate storage area in the medication room to a designated box/container by a team of a nurse and another staff member and documentation of the date and the unit the medications are noted in a log book by both team members.
-Destroy medications so their consumption is rendered impossible or improbable (i.e. covering with a small of liquid or cream).
On June 18, 2014 interview with the Resident Care Coordinator indicated most of the medications for destruction remain in the original packaging and when covered with liquid /cream the medications have not been altered or denatured to the extent that their consumption is rendered impossible or improbable. [s. 136. (6)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 229 (10) 1 in that each resident admitted to the Home must be screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Interview with the Licensee's Occupational Nurse and Infection Prevention Coordinator and Registered staff #118 indicated that it is the licensee's practice for those residents who are 65 years of age and above to have a chest x-ray for tuberculosis screening and to use the 2 Step Tuberculin Skin Test for Tuberculosis screening for resident who are less than 65 years of age.

A review of Resident #008's and Resident #007 both the residents' clinical records indicated that the residents were not screened for tuberculosis prior to admission and had not been screen for tuberculosis within 14 days of admission to the home. Interview with Registered Nurse #118 confirmed that Resident #008 and Resident #007 have not been screened for tuberculosis as of June 17th 2014. [s. 229. (10) 1.]

Issued on this 26th day of June, 2014

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