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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Amended Public Copy/Copie modifiée 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
Sep 22, 2021	2021_595110_0009 (A1)	008515-20, 013335-20, 001978-21, 006434-21	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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date was requested and extended October 29, 2021.

Issued on this 22nd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by DIANE BROWN (110) - (A1)

Amended 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): June 24, 25, 30, 2021. July 2, 5-9, 12, 2021.

The following intakes were inspected during this Critical Incident (CI) inspection:

Logs #008515-20, #013335-20, #001978-21 and #006434-21 related to a resident fall resulting in transfer to hospital and significant change in status.

A Cooling and Air Temperature Inspection and Infection Prevention and Control Inspection was also completed.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Manager of Nursing Practice, Resident Care Coordinators, Physiotherapist, Occupational Therapist, Registered Nurses, Registered Practical Nurses, Environmental Services Manager, Environmental Supervisor, Health Care Aides, Personal Support Workers, Resident Care Assistant.

During the course of this Inspection, the Inspector toured resident home areas, observed infection control practices and air temperature. Reviewed clinical health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care set out clear directions to staff

and others who provide direct care to the resident.

A CI (Critical Incident) was submitted to the Ministry of Long-Term Care reporting resident #001's fall with injury.

A review of the written plan of care, in place prior to the resident's fall, revealed a care plan focus related to their risk of fall that was initiated at least a year and one half prior to the residents fall.

The care plan stated to ensure the resident used an assistive device (specify: cane, walker, raised toilet seat, high low bed etc.). The type of assistive device was not specified or individualized for over a year and one half time period and prior to the residents multiple falls and did not provide clear direction to staff and others who provide direct care.

Sources: written care plan and interviews with PSWs, HCAs and RN #102. [s. 6. (1) (c)]

2. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A CI was submitted to the Ministry of Long-Term Care reporting resident#001's fall and subsequent significant change in status when the resident attempted to self-transfer.

A record review identified the resident having had multiple falls in the five months leading up to the resident's reported fall with injury and significant change in status.

1. Six weeks prior to the reported fall and injury a multidisciplinary data set (MDS) assessment, completed by nursing, documented the resident's significant change in status that included a decline in their activities of daily living from independent to one person physical assistance for transfer and toileting. An interview with the Occupational Therapist (OT), often responsible for posting transfers logo confirmed the resident's transfer logo to communicate the new transfer status had not been changed after the MDS assessment. The resident's written plan of care continued as independent in transfers and toileting.

An interview with the PSW who assisted the resident with morning care on the day of the resident's fall with injury revealed they had used transfer equipment along with two staff during morning transfers. Further interviews with registered staff and PSWs stated the resident required the assistance of at least one and often two staff when transferring, for approximately 6 months prior to their reported fall with significant injury. The licensee failed to ensure staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other with respect to the resident's transfer and toileting assistance.

2. During resident #001's prior falls, staff witnessed the circumstances around the fall and PSWs had to lower them to the ground. An interview with the Physiotherapist (PT) revealed that registered staff should have completed a referral for a PT reassessment. A record review failed to identify a referral or reassessment by the PT of the resident's standing tolerance after this fall. The licensee failed to ensure staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Sources: progress notes, written plans of care, fall incident reports, PT and OT assessments, interviews with PSWs #101, #104, RN #102. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CI was submitted to the Ministry of Long-Term Care reporting resident #001's fall with significant injury.

1. A review of the written plan of care, in place prior to the resident's fall, revealed a risk of falls focus that was initiated . An intervention related to the fall focus was initiated at least a year and one half prior to the residents fall and directed staff to assess for the correct bed height and mark wall with tape to demonstrate to all team members.

An interview with PSWs and registered staff confirmed that no one had assessed

the correct bed height and marked the wall with tape according to the plan of care in the year and one half.

2. The resident's plan of care, prior to the resident's reported fall included a PT assessment identifying the resident requiring a one person assistance with transfers for safety. The resident self transferred at the time of the fall and was not assisted as set out in the plan of care for their safety.

Sources: progress notes, written plans of care, fall incident reports, PT and OT assessments, interviews with PSWs #101, #104, RN #102. [s. 6. (7)]

4. A CI was submitted to the Ministry of Long-Term Care reporting that resident #004 was walking, lost their footing, fell and sustained a significant change in health status.

At the time of the resident's fall, the resident's written plan of care identified that the resident required one staff to walk with them and their walking aid. According to the PT and PSW #109, the resident's health condition meant they could be unsteady while walking with their aid so one staff was required to closely monitor and guide the resident in case they lost their balance.

PSW #112 who provided care to resident #004 at the time of their fall stated they were unaware the resident required one person assistance and confirmed the plan of care had not been followed at the time of the resident's fall.

Sources: written plan of care, progress notes, MDS assessments. Staff interview with RPN #111, RN #110, PSWs #109, #112 and PT #107. [s. 6. (7)]

5. A CI was submitted to the Ministry of Long-Term Care reporting resident#003's fall, injury and significant change in health status.

A record review identified the resident as having four prior falls since admission two months prior to the reported fall with injury.

The plan of care in place, at the time of the fall, identified the resident requiring two staff and equipment for transfers and the assistance of two staff with a mobility aid for walking.

On the day of the fall, RN #117 identified that Resident Care Assistant (RCA)

#113 was walking the resident to their room and was told by the RCA that resident #003 lost their balance trying to reach to the chair. The Fall incident report shared a consistent explanation. An interview with the RCA confirmed they were walking with the resident with their mobility aid into their room and the resident fell. The RCA could not recall the circumstances around the resident's fall.

The licensee failed to provide the level of assistance and proper transfer technique as set out in the resident's plan of care.

Sources: Care plan,progress notes Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, #115, #114, RN #110, RPN #111, RCA, PT and the Manager of Nursing Practice. [s. 6. (7)]

6. The licensee failed to ensure 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 was no longer necessary.

A CI was submitted to the Ministry of Long-Term Care reporting resident #001's fall with injury. The resident fell during a self transfer and self toileting.

The written plan of care for transfers and toileting was last updated approximately a year and one half prior and identified the resident as independent.

Interviews with RN, PT and PSWs revealed that over the year and one half and prior to the resident's reported fall that the resident had deteriorated and required staff assistance with transferring and toileting. Staff confirmed the plan of care had not revised when the resident required more assistance with transfers and toileting.

A further interview with the Occupational Therapist confirmed the resident's transfer logo was independent at the time of admission, one year and a half ago and had not been changed when the resident's care needs required staff assistance.

Sources: progress notes, written plans of care, fall incident reports, PT and OT assessments, interviews with PSWs #101, #104, RN #102, PT and OT. [s. 6. (10) (b)]

7. The licensee failed to ensure that when the resident was being reassessed and the plan of care revised, because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

A CI was submitted to the Ministry of Long-Term Care reporting resident#001's fall with injury and significant change in health status.

At the time of the reported fall, the resident's location led to staff believing they had been trying to self-transfer.

Resident #001 had multiple prior falls all identifying the resident was attempting to self transfer. The fall incident reports revealed that after each fall staff reminded the resident to use the call bell for assistance with transfers.

The Physiotherapist assessment prior to the resident's reported fall with injury identified the resident requiring one person assistance for transfers for safety but that the resident always self-transferred. PSW and registered staff interviews identified that the resident would forget to use the call bell or consider themselves independent and attempt to self-transfer. Staff confirmed that relying on the resident to use a call bell for transfer assistance was not an effective intervention in keeping them safe from self-transferring and preventing a fall. Staff interviews revealed an awareness that different approaches should have been considered for resident #001 in preventing them from self transferring and falling.

The licensee failed to consider different approaches in the revision of the plan of care after resident #001's falls when the care set out in the plan has not been effective in preventing the resident from falling.

Sources: Fall Incident Reports and Post Fall Huddle, Progress notes, plan of care, RPN #100, RN #102, PSWs #108, #104. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 70/10, s. 48(1)1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The Homes' 'Fall Prevention and Management Policy' directs:

1. The Interprofessional Team to ensure the care plan is updated in a timely fashion.

Resident #001 fell while self-transferring and subsequently sustained a significant change in health status. The resident had multiple falls in five months leading to the fall with injury.

The written plan of care for the resident's transfers and toileting status was

independent and last updated one and one half years prior to residents fall with injury. Interviews with RN, PT and PSWs revealed that for months prior to the resident's serious fall the resident had deteriorated and required staff assistance with transferring and toileting. Staff confirmed the plan of care had not been updated to reflect the resident requiring more assistance with transfers and toileting.

2. The Physiotherapist shall conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #001 at the time of their reported fall with serious injury.

Sources 'Fall Prevention and Management Policy' # INTERD-03-08-01 [s. 8. (1)]

2. The Homes' 'Fall Prevention and Management Policy' directs:

1. Registered staff, after a resident has fallen, are to complete an assessment regarding the cause, the environmental factors and the post fall care needs.

Resident #004 fell and sustained a significant change in health status.

A review of the fall incident report identified the contributing factor was an unsteady walking pattern.

Interviews with PSWs and the PT along with a record review identified the resident, prior to their fall, with a known unsteady walking pattern and therefore had required a one person assist to guide and supervise them while walking and using their mobility aid.

An interview with the RN and RPN who attended to resident #004 after their fall and the RN who completed the falls incident report stated the resident lost their balance. Both staff were unaware the resident's plan of care that identified the need for a one person assistance along with their mobility aid while ambulating due to their unsteady walking pattern.

An interview with the Manager of Nursing Practice, lead for falls prevention in the home, confirmed they completed the CI report submitted to the Ministry for the fall. The Manager was unaware that the resident’s need for a one person

assistance while ambulating had also not been in place at the time of their fall. The Manager confirmed the home's fall score was above the provincial average and they were working with registered staff to facilitate enhanced critical thinking during post fall assessments.

The RN failed to identify the lack of staff assistance as a possible cause of the resident's fall and according to the home's policy to aid in identifying the issue to reduce further incidents of falls.

2. The Physiotherapist to conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #004 at the time of their reported fall with serious injury.

Sources: Care plan, progress notes, Critical Incident M546-000006-21, 'Fall Prevention and Management Policy' # INTERD-03-08-01 Dated December 14, 2018. Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, RN #110, RPN #111, PT and the Manager of Nursing Practice. [s. 8. (1)]

3. The Homes' 'Fall Prevention and Management Policy' directs:

1. Registered staff, after a resident has fallen, to complete an assessment regarding the cause, the environmental factors and the post fall care needs.

Resident #003 fell and sustained an injury and significant change in health status.

A review of the fall incident report identified the resident was being assisted by one staff to their room. When the resident entered their room they lost their balance and fell. The identified contributing factor was that the resident lost their balance trying to reach to the chair. The plan was to continue with the current care plan.

Resident care assistant (RCA) #113 was present at the time of the resident's fall. An interview with the RCA revealed they were walking with the resident to their room and the resident fell inside their room. The PCA could not recall the circumstances around the resident's fall and directed the Inspector to speak to RN #117 who was aware of the details.

A review of the resident's plan of care at the time of the resident's fall identified the resident requiring transfer equipment along with two staff and the assistance of two staff with a mobility aid for locomotion according to the latest Physiotherapy assessment. PSW interviews confirmed they used two staff for transferring the resident along with transfer equipment.

An interview with RN #117, who attended to resident #003's fall and whom completed the falls incident report stated they were told by the RCA that resident #003 lost their balance trying to reach the chair to sit. The RN was unaware the resident's plan of care identified a transfer equipment and for two staff and mobility aid for walking and that the lack of proper assistance for walking and transferring may have contributed to the resident's fall.

A review of the fall incident report and CI report submitted to the Ministry failed to include the lack of assistance for locomotion and proper transfer technique at the time of the residents fall.

The RN failed to identify the lack of assistance for locomotion and proper transfer technique as a possible cause of the resident's fall and according to the home's policy to aid in identifying the issue to reduce further incidents of falls.

2. The Physiotherapist to conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #003 at the time of their reported fall with serious injury.

Sources: Care plan, progress notes, Critical Incident M546-000006-21, 'Fall Prevention and Management Policy' # INTERD-03-08-01 Dated December 14, 2018. Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, #115, #114, RN #110, RPN #111, PT and the Manager of Nursing Practice. [s. 8. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing, at a minimum in the following areas of the home: 1. At least two resident bedrooms in different parts of the home. 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

On June 25, 2021, the Inspector requested for the Environmental Services Manager (ESM) to provide the home's air temperature records. The ESM was unable to produce documentation and confirmed that they had not been measuring and documenting air temperatures in the home.

Maintenance staff #107 indicated they would only measure the air temperature if they received a complaint and air temperature was not measured and documented in writing, at a minimum in the required areas of the home.

Sources: Interviews with the ESM, Environmental Supervisor and the Executive Director . [s. 21. (2)] [s. 21. (2) 2.]

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 air temperature was measured and documented in writing, at a minimum in the required areas of the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes protocols for referral of resident to specialized resources where required.

O. Reg. 70/10, s. 48(1)1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The home had an Occupational Therapist (OT) full time on staff. An interview with the OT confirmed their participation in the Homes' Fall Prevention Program. A review of the homes' 'Fall Prevention and Management Policy' and an interview with the Manager of Nursing Practice confirmed the policy did not include reference to the OT and protocols for referral of resident to specialized resources where required.

Sources: Fall Prevention and Management Policy INTERD-03-08-01 Revised November 2018. Interviews with OT, RN #117 and the Manager of Nursing Practice. [s. 30. (1) 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 for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes protocols for referral of resident to specialized resources where required, to be implemented voluntarily.

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

Issued on this 22nd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2021_595110_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008515-20, 013335-20, 001978-21, 006434-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 22, 2021(A1)
Licensee / Titulaire de permis :	Regional Municipality of Durham 605 Rossland Road East, Whitby, ON, L1N-6A3
LTC Home / Foyer de SLD :	Lakeview Manor 133 Main Street, P.O. Box 514, Beaverton, ON, L0K-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mike MacDonald

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Regional Municipality of Durham, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCH Act.

Specifically, the licensee must:

1. Ensure staff are kept aware of each resident's transfer and mobility status.
2. Ensure that residents are provided with their needs for mobility and transfers.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

1. A CI was submitted to the Ministry of Long-Term Care reporting resident#001's fall with significant injury.

A review of the written plan of care, in place prior to the resident's fall, revealed a risk of falls focus. An intervention related to the fall focus was initiated at least a year and one half prior to the resident's fall and directed staff to assess for the correct bed height and mark wall with tape to demonstrate to all team members.

An interview with PSWs and registered staff confirmed that no one had assessed the correct bed height and marked the wall with tape according to the plan of care in the year and one half.

2. The resident's plan of care, prior to the resident's reported fall included a PT assessment identifying the resident requiring a one person assistance with transfers for safety. The resident self transferred at the time of the fall and was not assisted as set out in the plan of care for their safety.

Sources: progress notes, written plans of care, fall incident reports, PT and OT assessments, interviews with PSWs #101, #104, RN #102. [s. 6. (7)]
(110)

2. A CI was submitted to the Ministry of Long-Term Care reporting that resident#004 was ambulating, lost their footing, fell and sustained a significant change in health status.

At the time of the resident's fall, the resident's written plan of care identified that the resident required one staff to walk with them and their walking aid. According to the PT and PSW #109, the resident's health condition meant they could be unsteady while walking with their aid so one staff was required to closely monitor and guide the resident in case they lost their balance.

PSW #112 who provided care to resident #004 at the time of their fall stated they were unaware the resident required one person assistance and confirmed the plan of care had not been followed at the time of the resident's fall.

Sources: written plan of care, progress notes, MDS assessments. Staff interview with RPN #111, RN #110, PSWs #109, #112 and PT #107. [s. 6. (7)]
(110)

3. A CI was submitted to the Ministry of Long-Term Care reporting resident#003's fall, injury and significant change in health status.

A record review identified the resident as having four prior falls since admission, two months prior to the reported fall with injury.

The plan of care in place, at the time of the fall, identified the resident requiring two staff and equipment for transfers and the assistance of two staff with a mobility aid for walking.

On the day of the fall, RN #117 identified that Resident Care Assistant (RCA) #113 was walking the resident to their room and was told by the RCA that resident #003 lost their balance trying to reach to the chair. The fall incident report shared a consistent explanation. An interview with the RCA confirmed they were walking with the resident with their mobility aid into their room and the resident fell. The RCA could not recall the circumstances around the resident's fall.

The licensee failed to provide the level of assistance and proper transfer technique as set out in the resident's plan of care.

Sources: Care plan,progress notes Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, #115, #114, RN #110, RPN #111, PT and the Manager of Nursing Practice. [s. 6. (7)]

An Order was made by taking the following factors into account:

Severity: There was actual harm to residents #001, #003 and #004 when care related to mobility and transfers was not provided.

Scope: The scope of this non-compliance was widespread as three residents who had fallen and had a significant change in status had not been provided care according to their plan of care.

Compliance history: The licensee had a previous non-compliance to the same subsection of the Long-Term Care Homes Act, 2007.

(110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2021(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. (1) (b).

Specifically, the licensee must:

1. Ensure that the home implements their Fall Prevention and Management policy with the aim of reducing the incidence of falls and the risk of injury.
2. Ensure that physiotherapist and occupational therapist recommendations for fall prevention have been reviewed by registered staff and implemented.
3. In the internal reporting of fall incidents, registered staff along with the home's
Falls Lead shall investigate and document the suspected cause of the fall, if all
interdisciplinary fall interventions were being followed prior to the fall and an evaluation of their ongoing effectiveness and any new approaches to minimize the resident's risk of falls.
4. Educate registered staff on the expectation to complete an assessment regarding the cause and the environmental factors post fall, according to the home's policy and updating the written plan of care.

Grounds / Motifs :

1. The Homes' 'Fall Prevention and Management Policy' directs:

1. The Interprofessional Team to ensure the care plan is updated in a timely fashion.

Resident #001 fell while self-transferring and subsequently sustained a significant change in health status. The resident had multiple falls in five months leading to the fall with injury.

The written plan of care for the resident's transfers and toileting status was independent and last updated one and one half years prior to residents fall with injury. Interviews with RN, PT and PSWs revealed that for months prior to the resident's serious fall the resident had deteriorated and required staff assistance with transferring and toileting. Staff confirmed the plan of care had not been updated to reflect the resident requiring more assistance with transfers and toileting.

2. The Physiotherapist shall conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #001 at the time of their reported fall with serious injury.

Sources 'Fall Prevention and Management Policy' # INTERD-03-08-01 [s. 8. (1)] (110)

2. The licensee has failed to ensure that that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

O. Reg. 70/10, s. 48(1)1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The Homes' 'Fall Prevention and Management Policy' directs:

1. Registered staff, after a resident has fallen, to complete an assessment regarding the cause, the environmental factors and the post fall care needs.

Resident #004 fell and sustained a significant change in health status.

A review of the fall incident report identified the contributing factor was an unsteady walking pattern.

Interviews with PSWs and the PT along with a record review identified the resident, prior to their fall, with a known unsteady walking pattern and therefore had required a one person assist to guide and supervise them while walking and using their mobility aid.

An interview with the RN and RPN who attended to resident #004 after their fall and the RN who completed the falls incident report stated the resident lost their balance. Both staff were unaware the resident's plan of care that identified the need for a one person assistance along with their mobility aid while ambulating due to their unsteady walking pattern.

An interview with the Manager of Nursing Practice, lead for falls prevention in the home, confirmed they completed the CI report submitted to the Ministry for the fall. The Manager was unaware that the resident's need for a one person assistance while ambulating had also not been in place at the time of their fall. The Manager confirmed the home's fall score was above the provincial average and they were working with registered staff to facilitate enhanced critical thinking during post fall assessments.

The RN failed to identify the lack of staff assistance as a possible cause of the resident's fall and according to the home's policy to aid in identifying the issue to reduce further incidents of falls.

2. The Physiotherapist to conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #004 at the time of their reported fall with serious injury.

Sources: Care plan, progress notes, Critical Incident M546-000006-21, 'Fall Prevention and Management Policy' # INTERD-03-08-01 Dated December 14, 2018. Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, RN #110, RPN #111, PT and the Manager of Nursing Practice. [s. 8. (1)]

(110)

3. The Homes' 'Fall Prevention and Management Policy' directs:

1. Registered staff, after a resident has fallen, to complete an assessment regarding the cause, the environmental factors and the post fall care needs.

Resident #003 fell and sustained an injury and significant change in health status.

A review of the fall incident report identified the resident was being assisted by one staff to their room. When the resident entered their room they lost their balance and fell. The identified contributing factor was that the resident lost their balance trying to reach to the chair. The plan was to continue with the current care plan.

Resident care assistant (RCA) #113 was present at the time of the resident's fall. An interview with the RCA revealed they were walking with the resident to their room and the resident fell inside their room. The RCA could not recall the circumstances around the resident's fall and directed the Inspector to speak to RN #117 who was aware of the details.

A review of the resident's plan of care at the time of the resident's fall identified the resident requiring transfer equipment along with two staff and the assistance of two staff with a mobility aid for locomotion according to the latest Physiotherapy assessment. PSW interviews confirmed they used two staff for transferring the resident along with transfer equipment.

An interview with RN #117, who attended to resident #003's fall and whom completed the falls incident report stated they were told by the RCA that resident #003 lost their balance trying to reach the chair to sit. The RN was unaware the resident's plan of care identified a transfer equipment and for two staff and mobility aid for walking and that the lack of proper assistance for walking and transferring may have contributed to the resident's fall.

A review of the fall incident report and CI report submitted to the Ministry failed to include the lack of care plan assistance for walking and proper transfer technique at the time of the resident's fall.

The RN failed to identify the lack of assistance for walking and proper transfer technique as a possible cause of the resident's fall and according to the home's policy to aid in identifying the issue to reduce further incidents of falls.

2. The Physiotherapist to conduct a reassessment when a resident falls that results in serious harm.

A record review and interview with the PT confirmed they had not reassessed resident #003 at the time of their reported fall with serious injury.

Sources: Care plan, progress notes, Critical Incident M546-000006-21, 'Fall Prevention and Management Policy' # INTERD-03-08-01 Dated December 14, 2018. Incident Report- Falls (Incident Report and Post Fall Huddle)-V2, PT assessments, Staff interviews with PSW #112, #109, #115, #114, RN #110, RPN #111, PT and the Manager of Nursing Practice. [s. 8. (1)]

An Order was made by taking the following factors into account:

Severity: There was risk of harm to residents #001, #003 and #004 when the home's policy was not followed and registered staff failed to identify the lack of staff assistance as a possible cause of the resident's fall to aid in identifying the issue to reduce further incidents of falls.

Scope: The scope of this non-compliance was widespread as three residents who had fallen and had a significant change in status had not been reviewed according to the home's policy.

Compliance history: The licensee had a previous non-compliance to a different subsection of the Long-Term Care Homes Act, 2007. (110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of September, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by DIANE BROWN (110) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central East Service Area Office