Ontario

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
Jul 3, 2013	2013_049143_0034	O-000131-13	Complaint

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 11th-13th and July 2nd, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers, activity staff, a Physician, a dietary aide, an adjuvant therapist, residents and a family member.

During the course of the inspection, the inspector(s) reviewed resident health care records inclusive of plans of care, assessments, physician orders, admission agreement and fall prevention policies and procedures as well as observed meal service, resident care and services and recreational programming.

The following Inspection Protocols were used during this inspection:
Admission Process

Dining Observation

Falls Prevention

Medication

Minimizing of Restraining

Personal Support Services

Recreation and Social Activities

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. On a specified date a telephone conference was held with resident #1 Power of Attorney for Personal Care (POA). The Nurse Practitioner as well as the Director of Care were in attendance. During this telephone conference resident #1 fall prevention management was discussed. The POA requested that resident #1 be restrained. It was discussed that resident #1 is at risk for strangulation.
On a specified date a telephone discussion between the POA and inspector occurred. During this discussion the POA was questioned about the above telephone conference. The POA confirmed that this telephone conference occurred and indicated that a discussion of the risks and benefits of restraint use was discussed. The POA in discussion with the inspector on June 13, 2013 was not able to identify the risk and benefits of restraint use.
The licensee has failed to comply with the Long Term Care Homes Act sec. 6. (5) by not ensuring that the Substitute Decision Maker is given an opportunity to participate fully in the development of the plan of care. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A review of Resident #1 and #4 plan of care did not identify sleep patterns and preferences. On a specified date interviews were held with staff members #S119, #S108, #S105 and #S113 by the Inspector. It was confirmed by these four staff members that sleep preferences related to bedtime, naps and choices related to wakening up in the morning were not always addressed in the plan of care. Resident #1 preference was identified that she/he prefers to sleep in and naps in the afternoon which was not addressed in the plan of care.
The Licensee has failed to ensure that Ontario Regulation 79/10 sec. 26. (3) 21. plan of care addresses sleep patterns and preferences. [s. 26. (3) 21.]

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Issued on this 8th day of July, 2013

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