Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2016	2016_360111_0017	013501-16	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
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNDA BROWN (111), BAIYE OROCK (624), JULIET MANDERSON-GRAY (607)

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): August 24-26, September 1, October 26-27, 2016

The following critical incidents were completed concurrently during this inspection (log #024556-16 & #026057-16) related to alleged resident to resident sexual abuse; (log#025229-16) related to alleged resident to resident physical abuse and (log #026665-16) related to fall resulting in transfer to hospital and significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC), RAI Coordinator, Registered Nurses (RN), Occupational Therapist (OT), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, Medical Supply Representative, and Maintenance.

During the course of the inspection, the inspector(s) reviewed health records of current and deceased residents, reviewed the home's investigations into abuse allegations, and reviewed the following home's policies: Prevention of Abuse and Neglect & Falls Prevention Program

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
3 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	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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with RCC #114 (Falls Program lead), RCC #120 and the DOC by Inspector #111, during this inspection, indicated the "Falls-Nursing Post Falls Assessment" tool on paper is the clinically appropriate assessment instrument used for falls but is only completed when a resident sustains three falls in a one month period.

During the inspection, resident #006 was identified as sustaining a fall in the last 30 days. A review of the progress notes for resident #006 by Inspector #111, indicated during a six month period, the residents sustained five falls. The second and third fall resulted in minor injury and pain to a specified area. The fourth fall resulted in an injury requiring transfer to hospital and significant change in condition.

Review of the paper post-fall assessments indicated there were no post fall assessments completed for these falls, despite sustaining injury and/or pain post fall.

Interview with RCC #114 (Falls Program lead) & RCC #120 by Inspector #111, during this inspection, indicated there would be no post-fall assessment tool completed for this resident as the resident did not sustain more than three falls in any given month. [s. 49. (2)]

2. Re: Critical Incident Log # 026665-16 for resident # 049:

A critical incident report (CIR) was received by the Director on a specified date for a fall resulting in an injury and transfer to hospital. The CIR indicated resident #049 was found on the floor in room with an injury to a specified area and was unresponsive for a period of time. The resident was transferred to hospital and returned to the home palliative. The resident died three days later. The CIR indicated the resident was high risk for falls and sustained 35 falls since admission.

A review of the progress notes for resident #049 by Inspector #111, during this inspection, indicated the resident was admitted on a specified date and within a six month period, the resident sustained 80 falls and three near miss falls. The resident sustained injuries with 21 of the falls, and died three days later, after the last fall.

Review of the Falls-Nursing Post Falls Assessments for resident #049 indicated they were not completed for 34/70 of the falls.

There was no documented evidence a post fall assessment tool was completed after each fall for resident #006 & #049. The condition or circumstances indicated these residents had frequent, ongoing falls, some of which resulted in serious injuries, which therefore would indicate that a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was warranted after each fall. [s. 49. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were not charged for anything, except in accordance with the following: 4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged.

Under O.Reg 79/10, s. 245, Non-allowable resident charges, the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of
the Act:
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.except in accordance goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Under Long Term Care-Service Accountability Agreement (L-SAA) Policy: LTCH Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment:
The licensee must provide the following goods, equipment, supplies and services to long-

term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. The list of the goods, equipment, supplies and services the licensee must ensure is provided to residents, where not covered under another government program, is non-exhaustive and does not include a complete list of the goods, equipment, supplies and services the licensee must ensure is provided to residents to meet the requirements under O. Reg. 79/10. The classification of an expenditure into a particular funding envelope is determined in accordance with the Ministry's policy for classifying eligible expenditures and is not reflected in the order or organization of the following list:
2.1.12 Other Supplies and Equipment-Other supplies and equipment including but not limited to:
c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

Re: critical incident Log # 026665-16 for resident # 049:

Review of the progress notes for resident #049 indicated on a specified date, a referral was sent to the Occupational Therapist (OT) for fall protective equipment for the resident. The OT discussed with the family the protective equipment available related costs. The family agreed to the purchase of one of the fall protective equipment and the charge of $100.00. The OT then placed an ordered to the medical supply vendor and fall protective equipment was provided to the resident the following day.

Telephone interview with the OT by Inspector #111, on a specified date indicated residents who have fallen are referred to PT and/or OT by the registered nursing staff. The OT indicated whenever a resident has fallen, they would assess the resident and determine possible fall protective equipment (e.g. hip protectors, helmets, knee pads, elbow pads, etc) that could be used to reduce possible injury. The OT indicated the home's medical supply vendor is then contacted as they supply the equipment and to determine related costs. The OT indicated the family is then contacted by OT of the equipment and related costs for approval to purchase. The OT confirmed that resident #049 was charged and paid $188.60 for the specified fall protective equipment. The OT also confirmed that other residents were charged and paid for fall protective equipment. The OT was not aware that residents were not to be charged for fall protective equipment.

Telephone interview with the Administrator on a specified date indicated both himself and the DOC were not aware that the OT was having families pay for fall protective equipment from the home's medical supply vendor.

Telephone interview with the medical supply vendor by Inspector #111 during this inspection, provided a list of residents that paid for fall protective equipment at the home. Review of the list provided by the medical supply vendor indicated four deceased residents were charged and paid for fall protective equipment: resident #049- $188.60 for hip protectors; resident #053-$226.00 for helmet; resident #054-$188.60 for hip protectors and resident #055-$94.30 for hip protectors. [s. 91. (1)]

Additional Required Actions:

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

WN #3: 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. (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. (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 that care set out in the plan of care related to responsive behaviours for resident # 045 was provided to the resident as specified in the plan of care.

Re: critical incident Log #024556-16 for resident # 045 & #046:

Review of the health care record for Resident #045 & #046 by Inspector #624, indicated resident #045 & #046 were admitted on specified dates with a diagnoses that included cognitive impairment and were on a secure unit of the home.

Review of a critical incident report (CIR) received by the Director on a specified date for a suspected resident to resident sexual abuse incident indicated resident #046 was observed with a worried facial expression and saying “help me.” The CIR indicated an assessment of resident #046 revealed the resident was wearing an article of clothing that belonged to resident #045. Resident’s #046’s articles of clothing were later found in resident #045’s room. Both residents were unable to indicate how the articles of clothing were in residents # 045’s room due to cognitive impairment.

A review of resident # 045’s written care plan by Inspector #624, during this inspection, revealed an intervention (implemented prior to incident) which stated that resident #045 had an alarming device on the resident's door that was to be activated and used 24/7 to alert staff to resident #045’s or a co-resident entering or exiting resident #045’s room.”

During this inspection, at a specified time, resident #045 was observed (by Inspector #624) to have another resident (resident #046) in the room. When the Inspector asked to speak to resident #046, resident #045 became angry and told the Inspector to leave. Resident #045 proceeded to exit the door and come towards the Inspector. The door alarm did not go off. PSW # 119 was notified and redirected resident #046 away from the room without any resistance from both residents. On a second specified date, resident #045 was observed by Inspector #624 to be in the room with the alarming door device not activated. Interview with RPN #105 by Inspector #624 confirmed the door alarm was not applied and was supposed to be applied as per the care plan.

In an interview with the DOC and RCC #120, both confirmed the infrared door alarm is to be applied, as specified in resident #045 written care plan. [s. 6. (7)]

2. The licensee has failed to ensure that when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care related to falls risk.

During the inspection, resident #011 was identified as sustaining a fall in the last 30 days. Review of the progress notes for resident #011 by Inspector #111, during the inspection, indicated the resident was admitted on a specified date with a history of falls

and injury. The resident sustained seven falls in a five month period: and sustained an injury to specified areas after three of the falls. After the seventh fall, the resident was referred to and assessed by the Physiotherapist (PT) and indicated resident refused strength training exercises and therefore, no PT program. The resident was then referred to and assessed by OT "re: nursing concerns" related to poor mobility aide use and the OT recommended a trial of 'slow down brakes' for the mobility aide.

Review of the current written plan of care for resident #011, by Inspector #111, indicated the resident was at risk for falls related to history of falls and medication. Interventions included: ensure bed is positioned at appropriate height for resident to transfer on and off, ensure call bell is within reach and remind to call for assistance, and ensure proper footwear. There was no indication related to level of risk or the use of a mobility aide.

Interview of RPN #117, RCC#114, RCC #120 and DOC indicated when the resident is admitted, a Fall Risk Prevention Interventions tool is to be completed which lists interventions to be used based on level of risk and these interventions are to be included in the care plan. They all also indicated a referral to PT/OT is to occur after every fall.

Review of the Fall Risk Prevention Interventions tool for resident #011 indicated the resident was 'medium risk' but the remainder of the tool was blank (no interventions were selected).

Resident #011 fell (on the day of admission) and seven additional times in a five month period, and the resident was not referred to OT and PT until after the seventh fall. The plan of care was not revised to indicate the level of risk for falls, and additional interventions were not considered when the interventions used were not effective in reducing the number of falls. [s. 6. (11) (b)]

3. During inspection, resident #006 was identified as sustaining a fall in the last 30 days. A review of the progress notes for resident #006 by Inspector #111, during this inspection, indicated during a six month period, the resident sustained five falls during the six month period.

On admission, the Fall Risk Prevention Interventions tool was blank (not completed) and no documented evidence of this tool being completed since admission.

Review of the current written care plan for resident #006, by Inspector #111, during this inspection, indicated the resident was at risk for falls related to history of falls with a

fractured left hip. Interventions included: currently non-ambulatory (bed/chair fast) due to post surgery for fractured left hip. "When and/if resident becomes ambulatory: ensure wearing non-slip foot wear, remind to use walker, environment is well lit and clutter free, encourage to walk slowly and deliberately, ensure has adequate rest periods". Additional interventions included: monitor blood sugars, fall mats put in place on opposite sides of bed on floor, chair/bed alarm due to increased restless with attempting to climb our from bed.These interventions were in place after the resident returned from hospital and were not revised after the resident was returned to being ambulatory.

Interview with PSW #116by Inspector #111, during this inspection, indicated resident #006 was a moderate risk for falls due to recent fall with fractured hip.

There was no indication the written plan of care for resident #006 was revised when the resident continued to fall, to indicate the level of risk for falls, and other interventions were considered when the interventions in place were ineffective. [s. 6. (11) (b)]

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 the care set out in the plan for residents with responsive behaviours, is provided as specified in the plan, and when the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, related to falls risk, different approaches were considered in the revision of the plan of care., to be implemented voluntarily.

WN #4: 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 :

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

Under O.Reg.79/10, s.48(1)The licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program top reduce the incident of falls and the risk of injury.

Interview with the DOC indicated the home's Falls Prevention policy included “Fall Prevention and Management Program” (INTERD-03-08-01), the ‘Lakeview Manor Program for Prevention of Falls and Fall injuries in the Older Adult’ and the ‘Prevention of Fall related injuries and Falls Prevention’ guideline. The DOC indicated the interdisciplinary "site quality council" was the Fall Prevention and Management Committee that meets quarterly and reviews fall stats in the home and discusses strategies to manage residents who have fallen. The DOC indicated RCC #114 was in charge of this committee.

Review of the home's policy “Fall Prevention and Management Program” (INTERD-03-08-01) revised April 2014 under procedure indicated:
-fall risk assessments will be completed within 24 hours of admission, quarterly, and change in health status that puts increased risk for falling. Screening Fall Risk Assessment score will determine risk status (low, medium, high) and ‘Falls Risk Prevention Interventions’ as determined by risk status will be initiated upon admission. Development of written resident focused plans of care incorporating interventions and strategies.
-homes will ensure the availability of resources to support resident plans of care including

restorative care approaches and equipment, supplies, devices and assistive aides.
-there is a clear process for immediate post-fall assessment in response to change in health status which puts a resident at increased risk for falling.
-Criteria for triggered, comprehensive post fall assessment will be established by the home.
Review of the 'Lakeview Manor Program for Prevention of Falls and fall injuries in the Older Adult' indicated: "the implementation plan incorporates the Falls Prevention and Management Policy (NUR-04-08-06). Includes: Fall Risk Assessment Tool (FRAT), Comprehensive Post-Fall Evaluation Form, Falls Prevention Medication Review, Falls-Nursing Post Falls Assessment. In addition, under step 1: establish a multidisciplinary steering committee for fall prevention and fall injury prevention.

Review of the 'Falls Prevention Program Guidelines' indicated:
-on admission, a Fall Risk assessment (FRAT) is completed by the RN to determine Fall Risk status (low, medium, high) and enters on care plan.
-Using 'Fall Risk Prevention Interventions' document, select and implement interventions appropriate for risk status. If risk is medium or high, post a high risk identifier at doorway or bedside.
-Re-assessment: reassess for fall risk when there is a change in condition, return from hospital or a fall.
-Post fall assessment: complete the post fall assessment when a resident has had more than two falls in a month, comprehensive post-fall assessment form, a medication review, and initiate referrals.

Review of the "site quality council" meeting minutes for 2016 by Inspector #111, during the inspection, indicated they were held quarterly and the Risk Management Report (which includes fall statistics) for the previous quarter is reviewed by the committee. The minutes for January 2016 indicated "continue to be vigilant about falls and fall prevention-suggestions is the proactive personal alarm monitoring for all newly admitted residents to prevent early admission falls ...this initiative is still pending". The meeting in May 2016 indicated "harmful fall rate remains low" (despite the falls rate indicating the number of falls in April and May 2016 increased and the number of fractures which resulted from falls increased and was now above the home's target goals). There was no indication of actions to be taken related to falls.

Interview with RCC #114 indicated no awareness she was in charge of the Falls Prevention Committee. The RN indicated the previous lead was no longer in the home. The RN indicated the 'screening fall risk assessment' used in the home was the 'Falls

Risk Assessment Tool’ (FRAT) and was completed with the ‘Fall Risk Prevention Interventions’ tool but only completed on admission, the interventions identified were then added to the plan of care and implemented. The RN indicated the process for post fall assessment included the ‘Nursing Post Falls Assessment’ tool and was only used after the third fall within a one month period.

Interview with RAI Coordinator, RCC #120, and the DOC also indicated the FRAT and the Fall Risk Prevention tool is only completed on admission, a progress note is completed after each fall but the Post Falls Assessment tool is only completed after every third fall in a month. They were unaware the home’s policy and guideline indicated the FRAT and Interventions tool was to be completed on admission, quarterly, after return from hospital, and after a fall. They were both unaware the guideline indicated the Post Falls assessment tool was to be completed after two falls in one month.

-Review of the fall statistics for each unit for 2016 indicated there were several residents who had sustained 2 or more falls in a month period but only the residents that sustained 3 or more falls in a month period had a post fall assessment completed.
-The policy indicated the FRAT tool was to be completed on admission, quarterly with RAI-MDS schedule and with a change in condition along with the fall risk prevention interventions. The level of falls risk was to be identified on the resident's care plan. The identifier tool was to be placed at doorway to alert staff of resident's at medium to high risk for falls.
-Interview with RN's, RPN’s(on different units), RCC's and the DOC by Inspector #111, during this inspection, indicated the FRAT and fall risk prevention intervention tool was only completed on admission. Interview of PSW's on different units either did not know what the leaf symbol was for, or what level of fall risk was associated with the leaf symbol that was to be placed inside the resident's memory box at the doorway.
-The home’s policy indicated the clinically appropriate assessment tool to be utilized was the ‘post fall assessment tool’ and was required to be completed after every third fall. There was clinical evidence that showed a post fall assessment should have been completed after each fall, as specified residents had frequent and ongoing falls, some with serious injury. Staff were also not aware or following the Falls Prevention and Management policy/guideline that was established in the home as:
-the guideline did not refer to the policy that was in use in the home (INTERD-03-08-01) but referred to another policy that the DOC indicated was an older policy and the DOC was not aware the home specific guideline did not refer to the home's current policy.
-for resident #049: a fall risk assessment was not completed (despite sustaining approximately 80 falls in a six month period) or after the resident continued to fall or

returned from hospital post-fall. Resident #049 plan of care also did not identify the risk level or all interventions identified with a resident at high risk for falls. A Fall Risk Intervention document was not completed for resident #049. The post fall assessment was only being completed if the resident had more than three falls in a month, and many of the falls did not have a post fall assessment completed. There was no Comprehensive Post-Fall Evaluation Form or Falls Prevention Medication Review form completed. The availability of fall protective equipment was only provided when the family purchased the items (i.e. hip protector).
-for resident # 011: the FRAT tool and Falls Prevention Interventions tool was not dated to indicate when it was completed and indicated the resident was a moderate risk for falls (despite sustaining 6 falls in three separate months). The interventions tool was also left incomplete. There was no Comprehensive Post-Fall Evaluation Form or Falls Prevention Medication Review form completed. The plan of care also did not identify the risk level.
-for resident # 006: the FRAT tool and Falls Prevention Interventions tool was completed on admission and indicated the resident was a moderate risk for falls. The interventions tool was also left incomplete. There was no documented evidence of Post Falls Assessments completed for any of the five falls the resident sustained (despite 2 falls occurring in one month period). There was no Comprehensive Post-Fall Evaluation Form or Falls Prevention Medication Review form completed. [s. 8. (1) (a),s. 8. (1) (b)]

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 the home's falls prevention and management program is complied with by all staff, to be implemented voluntarily.

WN #5: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Observations on three specified dates, by Inspector #111, indicated two specified resident rooms had Personal Protective Equipment (PPE's) in a dispenser on the door for staff to use, however did not have signs posted to indicate which type of precaution was in place or which PPE's were to be used.

Interview of RPN # 104 indicated one specified resident room was 'precautionary' as the resident had just returned from hospital and awaiting lab results from infection control screening and the second specified resident was on contact precautions. The RPN indicated both residents should have had signs posted to indicate which type of precaution was in place and the PPE's to be used. [s. 229. (4)]

2. During the tour of the home on August 9, 2016, by Inspector #607, five specified resident rooms were observed to have PPE's in a dispenser hanging on the door with no signage visible to indicate the type of precautions or what PPE's to be used.

A review of the home's "Routine practices and additional precautions contact, droplet and airborne" policy # IC-05-03-02, dated November 16, 2015 (page 4 of 7) indicated under Procedure for additional precautions: Post isolation sign at the entrance of the resident room.

Interview with PSW #107, #109, RPN #108 and RN #110 all confirmed that there was no signage posted on the above identified doors and also indicated the expectation is that there should be signage posted on each resident's door indicating what precaution staff should take prior to providing care for the above identified residents. [s. 229. (4)]

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 infection prevention and control program is implemented in the home, specifically related to posting which type of precautions are in place, as per the home's policy, and to alert staff and/or visitors to which PPE's are to be used, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors.

During the inspection, the following observations were noted by Inspector #607, related to the resident-staff communication and response system (call bells):
-On specified dates and times, resident #018’s call bell sitting on floor next to night stand at the foot of bed.
-On specified dates and times, resident #020’s call bell tucked underneath the resident’s mattress.

A review of the written plan of care for resident #018, by Inspector #607, indicated the resident was at risk for falls related to history of falls, medications and the resident will often leave mobility aide behind and also gets up during the night to go to bathroom.

A review of the written plan of care for resident #020, by Inspector #607, indicated the resident is at risk for falls related wandering and medications.

Interview with PSW # 118, by Inspector #607, during this inspection, confirmed that resident #018 & #020 call bells were not accessible and then proceeded to attach them both to the resident's pillows.

Interview with RN #113, by Inspector #607, during this inspection, confirmed that all call bells should be in place and accessible unless indicated otherwise in the care plan. [s. 17. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA, s. 86 (2) (b), by not ensuring there are measures in place to prevent the transmission of infections.

During this inspection, the following were observed by Inspector #607:
1)Beaver river unit (tub room): one used deodorant, three used nail clippers sitting on top of nail clipper bin, and one comb with hair debris. All items were observed unlabelled; (shower room): three combs with white debris on them and one soiled nail clipper which were observed unlabelled.
2)Harbour unit (shower room): two combs with hair debris, two nail clipper that were soiled, and two hair brushes with hair debris in them. The items were not labelled.
3)Hummingbird unit (tub room): one unlabelled hairbrush with hair debris in it.
5)Blue Heron Lane unit (tub room): four combs, one hair brush with hair debris, two tweezers, one soiled razor on sitting on a stool, two combs with hair debris in them sitting on top of paper towel holder, one hair brush by the sitting area close to the shower with hair debris in it and one soiled nail clipper. The items were not labelled. (shower room): eight unlabelled combs with hair debris in them, three soiled nail clippers and one soiled razor sitting on the counter. All items were unlabelled.

A review of the home's "Routine practices and additional precautions contact, droplet and airborne" policy # IC-05-03-02, dated November 16, 2015 (page 3 of 7) indicated personal care supplies (lotions, creams, soaps, nails clippers and razors) must be labelled and never shared between residents.

Interview with PSW #109, #118 and #108 indicated that all personal care items should be labelled including combs and brushes.

Interview with RN #113 confirmed that all personal care items should be labelled in shared bathrooms, tub rooms, including nail clippers, combs, and brushes. [s. 86. (2) (b)]

Issued on this 21st day of December, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), BAIYE OROCK (624), JULIET MANDERSON-GRAY (607)
Inspection No. / No de l'inspection :	2016_360111_0017
Log No. / Registre no:	013501-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2016
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 :	Susanne Babic

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee will prepare, submit and implement a corrective action plan that includes when the action is to be completed and by whom, and will include the following:
1.Review and revise the written plan of care for all residents determined to be at moderate to high risk for falls, to ensure the level of risk is indicated, and interventions are in place to reduce the possible risk of injury to those residents. This is to be completed immediately.
2. Review and revise the home's Falls Prevention and Management Program to ensure the screening of residents for falls risk, and any post fall assessment tools and guidelines used, are consistent with the O. Reg.79/10, s.49(2), and are the actual screening and post fall assessment tools and guidelines that are actually used in the home,
2. Retrain all the Registered Nursing staff on the home's revised Falls Prevention and Management Program,
3.Develop a process to monitor staff compliance to this revised Falls Prevention and Management Program to ensure compliance.

This corrective action plan is to be submitted to Lynda Brown, LTC Nursing Inspector, via email to: OttawaSAO.MOH@ontario.ca by January 3, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Interview with RCC #114 (Falls Program lead), RCC #120 and the DOC by Inspector #111, during this inspection, indicated the "Falls-Nursing Post Falls Assessment" tool on paper is the clinically appropriate assessment instrument used for falls but is only completed when a resident sustains three falls in a one month period.

During the inspection, resident #006 was identified as sustaining a fall in the last 30 days. A review of the progress notes for resident #006 by Inspector #111, indicated during a six month period, the residents sustained five falls. The second and third fall resulted in minor injury and pain to a specified area. The fourth fall resulted in an injury requiring transfer to hospital and significant change in condition.

Review of the paper post-fall assessments indicated there were no post fall assessments completed for these falls, despite sustaining injury and/or pain post fall.

Interview with RCC #114 (Falls Program lead) & RCC #120 by Inspector #111, during this inspection, indicated there would be no post-fall assessment tool completed for this resident as the resident did not sustain more than three falls in any given month. [s. 49. (2)]

2. Re: Critical Incident Log # 026665-16 for resident # 049:

A critical incident report (CIR) was received by the Director on a specified date for a fall resulting in an injury and transfer to hospital. The CIR indicated resident #049 was found on the floor in room with an injury to a specified area and was unresponsive for a period of time. The resident was transferred to hospital and returned to the home palliative. The resident died three days later. The CIR indicated the resident was high risk for falls and sustained 35 falls since admission.

A review of the progress notes for resident #049 by Inspector #111, during this inspection, indicated the resident was admitted on a specified date and within a six month period, the resident sustained 80 falls and three near miss falls. The resident sustained injuries with 21 of the falls, and died three days later, after the last fall.

Review of the Falls-Nursing Post Falls Assessments for resident #049 indicated

they were not completed for 34/70 of the falls.

There was no documented evidence a post fall assessment tool was completed after each fall for resident #006 & #049. The condition or circumstances indicated these residents had frequent, ongoing falls, some of which resulted in serious injuries, which therefore would indicate that a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was warranted after each fall. [s. 49. (2)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount.
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Order / Ordre :

The licensee is hereby ordered to:
1. Immediately stop charging or having Homestead charge all residents and/or the resident's substitute decision makers (SDM) for hip protectors, and any other fall protective equipment.
2. The licensee shall review resident #049, # 053, #054, & #055, and any other residents who are currently and/or have previously been charged for hip protectors, and any other fall protective equipment, to determine which residents were charged for those items, the amount charged, and reimburse the resident and or Substitute Decision Maker (SDM) for those charges.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not charged for anything, except in accordance with the following: 4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged.

Under O.Reg 79/10, s. 245, Non-allowable resident charges, the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.except in accordance goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Under Long Term Care-Service Accountability Agreement (L-SAA) Policy: LTCH Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment:
The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. The list of the goods, equipment, supplies and services the licensee must ensure is provided to residents, where not covered under another government program, is non-exhaustive and does not include a complete list of the goods, equipment, supplies and services the licensee must ensure is provided to residents to meet the requirements under O. Reg. 79/10. The classification of an expenditure into a particular funding envelope is determined in accordance with the Ministry's policy for classifying eligible expenditures and is not reflected in the order or organization of the following list:
2.1.12 Other Supplies and Equipment-Other supplies and equipment including but not limited to:
c. Equipment and supplies to ensure resident safety
d. Equipment and supplies to prevent resident falls

Re: critical incident Log # 026665-16 for resident # 049:

Review of the progress notes for resident #049 indicated on a specified date, a referral was sent to the Occupational Therapist (OT) for fall protective equipment for the resident. The OT discussed with the family the protective equipment available related costs. The family agreed to the purchase of one of the fall

protective equipment and the charge of $100.00. The OT then placed an ordered to the medical supply vendor and fall protective equipment was provided to the resident the following day.

Telephone interview with the OT by Inspector #111, on a specified date indicated residents who have fallen are referred to PT and/or OT by the registered nursing staff. The OT indicated whenever a resident has fallen, they would assess the resident and determine possible fall protective equipment (e.g. hip protectors, helmets, knee pads, elbow pads, etc) that could be used to reduce possible injury. The OT indicated the home's medical supply vendor is then contacted as they supply the equipment and to determine related costs. The OT indicated the family is then contacted by OT of the equipment and related costs for approval to purchase. The OT confirmed that resident #049 was charged and paid $188.60 for the specified fall protective equipment. The OT also confirmed that other residents were charged and paid for fall protective equipment. The OT was not aware that residents were not to be charged for fall protective equipment.

Telephone interview with the Administrator on a specified date indicated both himself and the DOC were not aware that the OT was having families pay for fall protective equipment from the home's medical supply vendor.

Telephone interview with the medical supply vendor by Inspector #111 during this inspection, provided a list of residents that paid for fall protective equipment at the home. Review of the list provided by the medical supply vendor indicated four deceased residents were charged and paid for fall protective equipment: resident #049- $188.60 for hip protectors; resident #053-$226.00 for helmet; resident #054-$188.60 for hip protectors and resident #055-$94.30 for hip protectors. [s. 91. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of December, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

Service Area Office / Bureau régional de services : Ottawa Service Area Office