Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

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Original Public Report

Report Issue Date: April 19, 2023	
Inspection Number: 2023-1563-0001	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Lakeview Manor, Beaverton	
Lead Inspector Sharon Connell (741721)	**Inspector Digital Signature** Sharon Connell Digitally signed by Sharon Connell Date: 2023.04.27 09:58:57 -04'00'
Additional Inspector(s) Patricia Mata (571)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 28, March 1, 8-10, 13, 15-17, 20, 2023 and offsite on the following date(s): March 2, 3, 6, 7, 14, 21, 28, 2023.

The following intake(s) were inspected:
- Critical Incident Report (CIR) related to abuse and responsive behaviours.
- CIR related to a fall.

The following intake was completed in the Critical Incident Systems inspection:
- CIR related to a fall.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect residents from abuse by resident #006.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse by a resident as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:

A Critical Incident Report (CIR) related to an allegation of physical abuse by resident #006 towards resident #019 was submitted to the Director.

A review of medical records indicated there were four incidents of physically responsive behaviours by resident #006 during a five-month period in 2022, that caused injury to residents #014, #015 and #019 and six additional incidents towards other residents that resulted in no injury.

Staff indicated that the resident was easily agitated and could get aggressive. The Behavioural Supports Ontario (BSO) staff member would assist if they were available, during their eight-hour shift, if the resident was in an agitated state.

During the five-month period when the incidents were occurring, several changes to the resident's plan of care were made. The resident's responsive behaviours continued. During the same period, on the fourth month, a physician recommended a specific intervention to protect residents until resident #006 was stable. This intervention was not put into place until 35 days later, after resident #006 caused injury to resident #019.

By failing to protect others from resident #006's physically responsive behaviours, the licensee put residents at risk of harm.

Sources: Review of progress notes, medication records, care plans, incident reports for resident #006 and medical records for resident #014, #015, and #019, and staff interviews (PSW, RPN, BSO RPN, BSO PSW, NP, and DOC). [741721]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report to the Director, an allegation of physical abuse by resident #006 towards resident #015.

Rationale and Summary:

Documentation indicated that an incident of responsive behaviour by resident #006, caused injury to resident #015 on a specified date.

The DOC acknowledged the incident did meet the legislated definition of physical abuse and should have been reported to the Ministry of Long-Term Care Director.

By failing to notify the Director of an allegation of resident-to-resident physical abuse, the licensee put residents at risk of harm.

Sources: Progress notes for resident #006 and #015, and DOC interview. [741721]

WRITTEN NOTIFICATION: Behaviour and Altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee failed to develop and implement interventions to minimize harm and risk of harm from resident 006's responsive behaviours towards other residents.

Rationale and Summary:

A Critical Incident Report (CIR) related to an allegation of physical abuse by resident #006 towards resident #019 was submitted to the Director.

On 12 separate occasions over a seven-week period in 2022, resident #006 displayed responsive behaviours that put other residents at risk of harm. Additionally, over a separate three-month period in 2022, resident #006 displayed responsive behaviours towards six co-residents that did not result in injury.

During the five-month period when these incidents were occurring, several changes to the resident's plan of care were made. The resident's responsive behaviour continued. During the same period, on the fourth month, a physician recommended a specific intervention to protect residents until resident #006 was stable. This intervention was not implemented until 35 days later when resident #006 caused injury to resident #019.

Two separate staff members and a Nurse Practitioner confirmed that the resident displayed responsive behaviours that put other residents at risk of harm.

By failing to develop and implement a plan that responded to resident #006's escalating responsive behaviours, the licensee placed other residents at continued risk for harm.

Sources: Resident progress notes, medication records, care plans, incident reports, external assessments/reports, and staff interviews (PSW, RPN, BSO RPN, BSO PSW, NP, and DOC). [741721]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1) The licensee has failed to ensure that their hand hygiene program included the removal of expired hand hygiene agents to maintain the 70% to 90% alcohol content required.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary:

Finding #1

Multiple expired hand sanitizers were found in use throughout the building including three resident home areas on the first, second and third floors, both inside and outside resident rooms and common areas.

Housekeeper #110 stated that they were responsible for checking for expired alcohol-based hand rub.

The Environmental Services Manager (ESM) stated that expired hand sanitizers were being replaced and the task of checking the hand sanitizer expiry dates will be included in the housekeeper's job routine. By failing to ensure that expired alcohol-based hand rub was replaced in the home, there was a risk to residents of transmission of infectious agents including the COVID-19 virus due to ineffective hand hygiene.

Sources: Interview ESM, Housekeeper #110, observations of resident rooms and common areas. [571]

Finding #2

On two separate days, wall dispensers were checked in two home areas, and most were found to have an alcohol-based hand rub (ABHR) product expiry date of either 2021 or 2022.

The ESM explained that they had just been informed about the expired alcohol-based hand rub (ABHR) and were in the process of ordering 200 units for the wall dispensers and would assign someone to replace the expired product once the shipment had arrived.

Failing to remove expired ABHR to ensure a 70-90% alcohol content was available for use, placed residents at risk of illness from transmission of infectious organisms.

Sources: Observations of ABHR wall dispensers, ESM interview. [741721]

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section IPAC Standard: Section 10.2

2) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022, (IPAC Standard), section 10.2 indicated the hand hygiene program shall be multifaceted and multidisciplinary. The licensee shall ensure that the program includes, at minimum, training and education, hand hygiene audits, a hand care program, and hand hygiene and hand care support for residents.

Rationale and Summary:

On two separate occasions, it was observed that residents on a resident home area did not receive assistance with completing hand hygiene before meals. PSW #126 and #105 acknowledged that they do not always aid residents with hand hygiene before meals.

In addition, during a meal service, RPN #127 did not perform hand hygiene before or after contact with resident #020 or #021. They acknowledged that they should have washed their hands.

The Resident Care Coordinator (RCC)/IPAC Lead indicated that staff were expected to perform hand hygiene before and after resident contact and hand hygiene should have been offered to residents before their meal service.

Review of the licensee's "Hand Hygiene Program" policy and an interview with the IPAC Lead, both confirmed that residents were to be supported with hand hygiene prior to meals.

Failure to perform hand hygiene before and after contact with residents, placed residents at risk of harm due to possible transmission of infectious agents. Failure to prompt and support residents to complete hand hygiene placed staff and residents at risk for transmission of infectious agents.

Sources: Observations of hand hygiene support for residents, staff interviews (RCC/IPAC Lead, PSW #126, #105, RPN #127) and review of the hand hygiene policy. [571]

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section IPAC Standard: Section 10.4 (h)

3) The licensee failed to ensure that the Director's infection prevention and control (IPAC) standard was followed as it relates to ensuring that residents receive hand hygiene support prior to their meals.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.4 states that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: (h) Support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary:

During a dining room observation several residents arrived on their own and began to eat without cleaning their hands. Staff did not offer hand hygiene assistance to residents before their meal.

Two residents were asked if they had cleaned their hands before coming to lunch, one said, no I wash my hands after I return to my room from a meal, and the other said, 'nobody told me too.'

The RPN was asked if the resident, who had come to the dining room on their own, would remember to clean their hands before eating, and they said sometimes their memory was good and other times not.

The IPAC lead and hand hygiene policy both noted that residents were to be supported with hand hygiene before meals.

Failure to ensure that residents were supported with hand hygiene before meals, placed residents at risk of illness from transmission of infectious organisms.

Sources: Resident interviews, dining room observations, staff interviews (RPN and IPAC lead). [741721]