Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 2, 2023	
Inspection Number: 2023-1563-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Lakeview Manor, Beaverton	
Lead Inspector Lynda Brown (111)	**Inspector Digital Signature** Lynda Brown
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4-6 and 10-13, 2023.
The inspection occurred offsite on the following date(s): July 14, 2023.

The following intake(s) were inspected:

- Intake: #00021437 - complaint regarding 24-hr RN coverage.
- Intake: #00084641 - Critical Incident (CI) regarding resident to resident abuse.
- Intake: #00090442 - CI regarding an injury for which a resident was transferred to hospital.
- Intake: #00091627 - CI regarding a respiratory outbreak.

The following intake(s) were also reviewed:

- Intake: #00090191 - CI regarding an injury for which a resident was transferred to hospital.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: 24-hour nursing care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)

The licensee has failed to ensure that at least one Registered Nurse (RN) who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

Rationale and Summary

An anonymous complaint was received by the Director related to RN staffing. The home has 149 beds and therefore, does not meet the exceptions as provided for in the regulations.

A review of the RN schedules during a number of months in 2023, indicated that on a number of dates and shifts, there was no registered nurse who was both an employee of the licensee and a member of the regular nursing staff on duty and present working in the home.

The Administrator confirmed that on identified dates, there were periods of time when there was no RN on-site due to staff sick calls. The DOC indicated the home outsourced their staffing schedules and replacement of staff and followed their back-up contingency plan. The DOC confirmed the home was unable to fill the RN shifts on the identified dates and indicated the home did not use nursing agency staff. The DOC indicated when the home was unable to replace an RN, they were to utilize an RPN to fill the shift and then have an RN on-call as needed.

Failing to have an RN on-site for a home with greater than 129 beds, places residents at risk.

Sources: RN schedules, interview of staff (DOC and Administrator). [111]

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WRITTEN NOTIFICATION: Pain Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director for a fall incident. The CI indicated the resident sustained an unwitnessed fall, complained of pain to a specified area and was transferred to hospital.

The resident returned from hospital a number of days later, with a diagnosis of a new injury. The Physiotherapist indicated due to severe cognitive impairment and pain, attempts for mobility were unsuccessful and no pain medication was given. A number of hours later, the resident was given a medication for a responsive behaviour with poor effect. A number of hours later, the physician was contacted for increased pain management and ordered a new pain medication given as needed (PRN) which was given with good effect. There was no documented pain assessment completed at that time.

The following day, during personal care, a PSW confirmed the resident was in a pain. There was no documented evidence the resident was given any pain medication. A number of hours later, the resident was given a medication for responsive behaviours. The resident was not given any pain medication until a number of hours later, despite having responsive behaviours indicating suspected pain.

The following day, the resident was sent back to the hospital for a change in condition and returned from the hospital a number of days later. The day after their return, the resident was given pain medication with good effect. A number of hours later, the resident was given a medication for responsive behaviours with poor effect. A number of hours later, the resident was given pain medication with good effect. There was no documented pain assessment completed at that time. The resident continued to deteriorate and a few days later, new palliative pain medication was ordered. The resident died a number of days later. There was no documented evidence a pain assessment was ever completed for the resident.

The care plan for the resident indicated the resident was to be assessed for pain using a pain assessment for cognitively impaired residents. The homes pain management policy indicated the registered staff

were to complete a comprehensive pain assessment upon the resident returning from hospital, the indication for the presence of any type of pain, or a change in clinical status related to an increase in pain and when pain is not relieved by initial interventions.

The DOC indicated that their expectation was for the registered staff to complete a pain assessment as per the home's pain management policy and according to the resident's assessed need.

Failing to complete a pain assessment for the resident when they had unrelieved new pain from an injury, when they had returned from hospital on more than one occasion and when their condition deteriorated, resulted in the resident having unmanaged pain.

Sources: CI, resident's health record, Pain Management policy, and interview with staff and the DOC. [111]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Rationale and Summary

A CI was submitted to the Director for a resident to resident abuse incident. An RPN witnessed a resident to resident altercation, that resulted in a fall and one of the residents sustaining an injury.

Clinical records for both residents indicated there was a prior altercation that occurred between both residents a number of days earlier and no injury was sustained by either resident.

The first resident's clinical records identified they had cognitive and hearing impairments, and demonstrated a number of responsive behaviours. The identified interventions used were ineffective. The resident also had a history of pain for which they received pain management as needed.

The second resident's clinical records identified they had cognitive and speech impairments, and

demonstrated a number of responsive behaviours which resulted in altercations with other residents. The resident also had identified triggers. The resident also had frequent complaints of pain and was given pain medication with good effect. The identified interventions, when used were effective.

The home's responsive behaviour policy directed the staff to complete specified assessments and staff were to document the incidents of responsive behaviours to assist the staff to understand and identify key triggers and successful interventions to manage and reduce the behaviours. The resident's plan of care was also to identify specific strategies to prevent and manage those responsive behaviours.

An RPN confirmed that one of the resident's required frequent monitoring due to responsive behaviours and the interventions used were ineffective. They confirmed the other resident would demonstrate responsive behaviours with identified triggers. The RPN confirmed they did not complete the specified assessments as per the policy for either resident, but they updated the resident care plans for responsive behaviours. They were unaware that one of the resident's care plan had not been updated to indicate the responsive behaviours, triggers, or strategies to prevent or manage their behaviours. They confirmed neither resident was placed in the Behavioural Support Ontario (BSO) program, despite more than one referral to BSO.

Failure to implement identified interventions for a resident, resulted in an altercation between resident two residents and one resident sustaining an injury.

Sources: CI, observations of two residents, clinical records for two resident s, responsive behaviour prevention and management policy, homes investigation records, and interview with an RPN. [111]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee failed to ensure that the nutritional care and hydration program included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration for a resident.

Rationale and Summary

A CI was submitted to the Director for a staff to resident abuse incident. The following day, an RN

documented the resident was found with a significant change in condition and the resident was transferred to the hospital. The hospital was contacted later the same day and indicated the resident's swallowing was to be reassessed. A number of days later, the resident returned from the hospital and there was no indication a referral was sent to the RD related to a new swallowing problem. A few days later, the resident's fluid intake had decreased, and the physician was contacted with new orders for hydration. There was no documented evidence a referral was submitted to the RD for a change in fluid intake. The residents condition continued to deteriorate and died a number of days later.

The homes policy for referral to registered dietitian (RD) guideline indicated the staff were to complete a referral to the RD for diet related issues, including a new swallowing problem or a change in their food and fluid intake.

An RN confirmed they suspected the resident had a change in swallowing and did not submit a referral to the RD. Interview with the RD confirmed they had not received a referral and had no awareness of the resident's change in swallowing or reduced fluid intake.

Failing to implement the nutritional care and hydration program including when to make a referral to the RD, resulted in a resident not being assessed by the RD and possible interventions implemented by the RD.

Sources: Dietitian Referral Guidelines policy, a resident 's health records and interview with the RN and RD. [111]

WRITTEN NOTIFICATION: Infection, prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

The licensee failed to report to Public Health as soon as possible when a number of residents had symptoms that met criteria for outbreak according to the home’s policy.

Rationale and Summary

A CI was submitted to the Director for a respiratory outbreak in the home that was declared by Public Health (PH).

Two residents on a specified unit began exhibiting symptoms of infection within 24 hours.

The home's policy for confirming an outbreak indicated the IPAC lead or designate, was to notify the PH of a suspected outbreak. The definition of the specified suspected outbreak included two cases of acute infection occurring within 48hours in the same geographic area (i.e., same home area, or floor).

PH indicated the home should be notifying PH when they meet the criteria as indicated in their outbreak policy. PH confirmed they were notified a number of days after the home suspected an outbreak, and placed the unit in a suspected outbreak. They indicated when another resident developed symptoms of infection on the same unit the next day, they declared the unit in outbreak.

The IPAC Lead confirmed the PH should have been notified when they met the criteria of a suspected outbreak.

Failing to notify PH of a suspected outbreak when identified, places the home at risk of further transmission of infection and delays prompt intervention by Public Health in managing the outbreak.

Sources: CI , two resident's clinical records, line listing, confirming an outbreak policy and interviews with the IPAC Lead and Public Health. [111]

WRITTEN NOTIFICATION: Infection, prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard 4.2 (e).

The licensee failed to ensure that as per the additional requirements under the standard, IPAC Standard 4.2, the IPAC Lead is involved in outbreak management activities in collaboration with the interdisciplinary IPAC team and the OMT in the manner described below. The IPAC Lead's role shall include, but not be limited to e) Implementing changes to IPAC practices as needed to support the outbreak response.

Rationale and Summary

A CI was submitted to the Director for a respiratory outbreak that was declared by PH, on a specified unit. Upon entering the home, the Inspector observed signage indicating a specified unit was in respiratory outbreak. Upon entering the unit, none of the staff or residents were observed wearing the required personal protective equipment (PPE) on the unit. Two resident rooms had signage on their doors indicating they were placed on specified precautions and staff were to wear specified PPE. Neither

of the residents were located in their rooms and were observed sitting in the main lounge, across from the nursing station, within proximity of several other residents, and not wearing the required PPE. Several staff were also observed sitting in front of the nursing station not wearing any of the required PPE and one staff was wearing the PPE incorrectly. The following day, there was a sign indicating that all staff and visitors entering the unit were to wear the required PPE prior to entering the unit.

Both the IPAC lead and the back-up IPAC lead indicated that due to cognitive impairment, some of the residents affected would not remain in their rooms. The PH Inspector indicated they had provided direction to the home to strongly encourage the staff to wear the required PPE due the residents being unable to remain isolated.

Failing to implement changes to IPAC practices, specifically donning the required PPE on a unit where affected residents would not remain in their rooms on specified precautions, placed other residents at risk for transmission of infection.

Sources: CI, observations, outbreak line listing, and interview of registered staff and PH. [111]

WRITTEN NOTIFICATION: Infection, prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that residents with symptoms of infection were assessed on each shift.

Rationale and Summary

The home was declared in a respiratory outbreak by PH. and the outbreak was declared over a number of days later.

Review of the clinical records for two residents indicated one of the resident's began exhibiting symptoms on one day and the following day, another resident began exhibiting the same symptoms. The clinical records for both residents indicated they did not have assessments documented on each shift, including vital signs completed for the duration of their infection symptoms.

The IPAC lead confirmed the expectation of registered staff was to monitor and assess each resident with symptoms of infection each shift and document in their progress notes.

The failure to monitor residents with symptoms of infection on each shift put residents at risk by not determining changes to residents' condition and any subsequent intervention required to support the residents' health and well being.

Sources: CI, outbreak line listing, two resident's clinical records, and interview with the IPAC lead. [111]

COMPLIANCE ORDER CO #001 Plan of Care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with FLTCA, 2021, s. 6(7).

Specifically, the licensee:

1. Educate the PSWs on Harbour unit on the use of fall's prevention interventions, specifically, the importance of ensuring residents who are required to have hip protectors in place, have them applied.
2. A falls prevention team member will review the plan of care for residents on Harbour unit, to determine which residents require the use of hip protectors. The falls prevention team member will conduct daily audits on Harbour unit for a 2 week period, on days and evenings, to verify identified residents are wearing their hip protectors as per their plan of care,
3. The falls prevention team member who identifies residents not wearing the hip protectors as indicated in the plan, will be reported to the DOC for further action.
4. The DOC, or designate, will take appropriate actions to address the residents who are not wearing their hip protectors.
5. A documented record will be kept demonstrating the education provided, audits completed, and corrective actions taken, when they were completed and by whom. The record is to be made immediately available to the Inspector upon request.

Grounds

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan related to falls.

Rationale and Summary

A CI was submitted to the Director for a fall of a resident that resulted in an injury. The resident was transferred to hospital for assessment and diagnosed with an injury. The CI indicated the resident had a history of falls, was to have a specified falls prevention intervention in place and was not in place at the time of the fall.

The plan of care for the resident indicated the staff were to apply the falls prevention intervention due to risk for falls.

A PSW and an RCC both confirmed that at the time of the fall, the resident was not wearing their falls prevention intervention and should have been.

Failing to ensure the plan of care for a resident was provided to the resident as specified in the plan related to applying a falls prevention intervention, resulted in the resident sustaining an injury.

Sources: CI, a resident health record and interview of staff [111]

This order must be complied with by: September 8, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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