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

Division de la responsabilisation et de la performance du système de santé
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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
Dec 3, 2012	2012_031194_0060	002630-11,002846-11,002911-11	Critical Incident System

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

Long-Term Care Home/Foyer de soins de longue durée

LAKEVIEW MANOR
133 Main Street, P.O. Box 514, Beaverton, ON, L0K-1A0

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 22, 23,26 & 27, 2012

Five Critical Incident inspections were completed during this inspection: Log #002630-11, #002846-11, #002911-11, #000068-12 and #000798-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Registered Nurse(RN),Registered Practical Nurse (RPN),Physician, RAI Co ordinator, Resident Care Co ordinators (RCC) and four residents.

During the course of the inspection, the inspector(s) Reviewed identified resident's clinical health records, licensee's investigation reports, relevant policies, Quality Improvement documentation related to falls and abuse, educational records, and five Critical Incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.53(4)(a) when triggers for resident #005 were not identified on the written plan of care for responsive behaviour.

A mental health assessment was completed for resident #005 outlining behaviours and possible triggers.

Documentation in the Critical Incident and the resident's progress notes confirm that an incident occurred between resident #004 and resident #005, resulting in an injury to resident #004.

The plan of care for resident #005 does not identify triggers or interventions to manage the aggressive behaviour.[s. 53. (4) (a)]

Issued on this 3rd day of December, 2012

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

Chantal Lafreniere (194)