



**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
Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 2013	2013_049143_0034	O-000131- 13	Complaint

Licensee/Titulaire de permis

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

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

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

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection



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

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

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

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

The following Inspection Protocols were used during this inspection:

Admission Process

Dining Observation

Falls Prevention

Medication

Minimizing of Restraining

Personal Support Services

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.



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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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :



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1. On a specified date a telephone conference was held with resident #1 Power of Attorney for Personal Care (POA). The Nurse Practitioner as well as the Director of Care were in attendance. During this telephone conference resident #1 fall prevention management was discussed. The POA requested that resident #1 be restrained. It was discussed that resident #1 is at risk for strangulation.

On a specified date a telephone discussion between the POA and inspector occurred. During this discussion the POA was questioned about the above telephone conference. The POA confirmed that this telephone conference occurred and indicated that a discussion of the risks and benefits of restraint use was discussed. The POA in discussion with the inspector on June 13, 2013 was not able to identify the risk and benefits of restraint use.

The licensee has failed to comply with the Long Term Care Homes Act sec. 6. (5) by not ensuring that the Substitute Decision Maker is given an opportunity to participate fully in the development of the plan of care. [s. 6. (5)]

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary
assessment of the following with respect to the resident:**

21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A review of Resident #1 and #4 plan of care did not identify sleep patterns and preferences. On a specified date interviews were held with staff members #S119, #S108, #S105 and #S113 by the Inspector. It was confirmed by these four staff members that sleep preferences related to bedtime, naps and choices related to waking up in the morning were not always addressed in the plan of care. Resident #1 preference was identified that she/he prefers to sleep in and naps in the afternoon which was not addressed in the plan of care.

The Licensee has failed to ensure that Ontario Regulation 79/10 sec. 26. (3) 21. plan of care addresses sleep patterns and preferences. [s. 26. (3) 21.]



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Issued on this 8th day of July, 2013

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

A handwritten signature in black ink, appearing to read "P. Miller", written within a rectangular box.