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

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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
Oct 10, 2014	2014_294555_0024	O-000932-14	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

FAIRVIEW LODGE
632 DUNDAS STREET WEST P.O. BOX 300 WHITBY ON L1N 5S3

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

GWEN COLES (555)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 9 and 10, 2014

This inspection was related to a Complaint Log #O-000932-14. Inspections were done concurrently related to Critical Incident Logs #O-000684-13 and O-000754-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Coordinator (RCC); Registered Nurse (RN); Registered Practical Nurse (RPN); Personal Support Workers (PSW); Environmental Services Manager (ESM) and Physiotherapist (PT).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Related to Log #O-000754-13:

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to residents.

Review of the Critical Incident report indicates that Resident #2 sustained an injury while being transferred from room to room in the home by staff. Resident #2 was assessed by registered staff and transferred to hospital for assessment and treatment. Family and the Physician were notified at the time of the incident.

Review of Resident #2's plan of care found no evidence of specific interventions related to transferring. Review of clinical records for Resident #2 indicated the resident required total assistance for locomotion on and off the unit. Review of clinical records indicated that "Resident poorly understand instructions..."

Interview conducted with Staff #105 who reported that support staff as part of their role help to transfer residents to the Dining Room for breakfast but was uncertain if Staff #108 had ever assisted this resident before. Staff #105 stated uncertain if anything was in Resident #2's plan of care regarding transferring. Staff #105 reports that the method of transfer for Resident #2 was verbally discussed with registered and personal support staff but uncertain about any formal communication method with support staff.

Interview conducted with Staff #101 who reports support staff are assigned to each unit to assist with transfers and are invited to attend unit interdisciplinary rounds where residents health status and issues are discussed. Interview with Staff #110 who reports support staff have a role to transfer residents and would get verbal direction from registered staff and personal support workers regarding which residents require assistance. Staff #110 reports there is no written direction related to transferring in Resident #2's plan of care.

Interview conducted with Staff #102 who reports that Staff #108 had not been assigned to that unit in over six weeks and therefore may not have been familiar with Resident #2. Staff #102 reports that support staff are expected to attend the every 2 week interdisciplinary rounds and be receiving daily verbal communication from nursing staff.

Interview with Staff #107 who reports the plan of care for Resident #2 has no reference

under ambulation/locomotion related to transferring. Staff #107 reports Resident #2 was unable to follow commands and required to be transferred in a certain way. Staff #107 reports communication about resident health status is done at report and at unit meetings which support staff do not always attend.

(PLEASE NOTE: This evidence of non-compliance was found during Inspection #2014_294555_0023.) [s. 6. (1) (c)]

2. Related to Log# O-000932-14:

The licensee has failed to ensure that the plan of care set out clear direction to staff and others related to falls prevention interventions.

Review of clinical records indicated that Resident #1 was found by staff to have had a fall resulting in injury. Resident #1 was assessed and treated, and subsequently the Substitute Decision Maker (SDM) requested floor mats to be put in place in the resident's room. During the course of the inspection Resident#1 was observed in bed, with the bed in lowest position, 2 fall mats noted - 1 located on each side of bed, 2 bed alarms in place on both sides of bed, and 2 quarter side rails raised.

Interview conducted with Staff #100 who reported Resident #1 has always had the bed in the lowest position, call bell in place, and 2 quarter side rails used. Staff was aware that since the fall floor mats on both sides of the bed and bed alarms are in place. Interview with Staff #104 who reported Resident #1's bed is always in lowest position, and there were no mats in place prior to recent fall, however since the fall the resident now has 2 fall mats and 2 bed alarms in place. Both staff reported that falls prevention interventions are found in the residents' care plan and a closet sheet located in the closet in the resident's room.

Review of clinical records indicated that Resident #1 was provided with two fall mats and two bed sensors and to continue to keep bed in lowest position.

Review of the most recent plan of care and posted closet sheet (Kardex) found no evidence of a falls prevention intervention related to floor mats and bed alarms. [s. 6. (1) (c)]

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 that the written plan of care sets out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Related to Log #O-000932-14:

The licensee has failed to ensure that procedures are developed and implemented to ensure that (iv) there is a process to report and locate residents' lost clothing and personal items.

Resident # 1's Substitute Decision Maker (SDM) reported to staff on a specified date that the resident was missing personal items. Review of records indicates Staff #100 completed a "Lost/Misplaced Personal Item Form" on that date reporting the missing item but found no evidence that the SDM was contacted within 1 or 2 weeks as specified on the form. Interview with Staff #100 who reported spoke with SDM three weeks later regarding the missing item and completed an additional missing item report. Review of records found no evidence of a Lost/Misplaced Personal Items form completed for that date, however an email was sent to the Administrator regarding the missing item. Review of records indicated the Environmental Department was in receipt of the initial Lost/Misplaced Personal Items form.

Interview conducted with Staff #100 who reported that environmental staff perform follow up on missing items and inform nursing when items are found. Staff #100 reported that it can take several weeks to possibly locate missing items and had advised Resident #1's SDM of that fact.

Interview conducted with Staff #102 who confirmed receipt of the initial missing personal item report and who reported that environmental staff are responsible for searching for missing issues. Staff #102 stated reporting the status of missing items to families is the responsibility of nursing and/or environment. Staff #102 reports due to Resident #1 status that it would be the responsibility of the facility to replace the missing item, and that it can take the laundry company up to 6 weeks to return any missing items due to schedule of linen pickups. Staff #102 is uncertain if SDM is aware of policy to replace lost items or timeliness of return schedule.

Review of Policy entitled "Laundry Service/Personal Clothing" OPER-06-01-19 dated December 3, 2010 found no evidence related to a procedure for Lost/Misplaced Personal Items including a form to be completed, who is responsible for follow up or when to consider replacement of items. Review of clinical records indicated that Resident #1's SDM was since contacted regarding the replacement of the missing item. [s. 89. (1) (a) (iv)]

Issued on this 21st day of November, 2014

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

Original report signed by the inspector.