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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Apr 20, 2016	2016_195166_0008	027067-15	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

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

CAROLINE TOMPKINS (166), LYNDA BROWN (111)

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): March 29 and April 1, 2016

Critical Incidents(CIR) log 027390-15, related to resident to resident abuse, logs 00336-16,002948-16, related to staff to resident abuse, log 024044-15 related to abuse(other)and log 027067-15 related to door security were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Director of Care(DOC), two Resident Care Coordinators(RCC), Behaviourial Support Ontario(BSO),Registered Practical Nurse(RPN), Registered Nurse(RN) and Nurse Practitioner(NP).
During the course of this inspection, the inspectors reviewed, the licensee's investigation documentation, staff education related to zero tolerance of abuse and neglect and clinical health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to 027390-15

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident (CIR) was received reporting an incident of resident to resident physical abuse.

Review of the CIR, clinical documentation, interview with the DOC and the RCC indicated a visitor witnessed an incident of resident to resident physical abuse between resident #003 and #004. The incident was reported to the charge RN on the same identified day.

This witnessed resident to resident physical abuse incident was not immediately reported to the Director until the licensee reported another incident of physical abuse by resident #004 directed towards resident #003, which occurred six days after the first incident.[s. 24. (1)]

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 to ensure that anyone who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Related to log 027390-15

The licensee has failed to ensure that every alleged, suspected or witnessed incident abuse of a resident by anyone that the licensee knows of or that is reported is immediately investigated.

During this inspection related to an incident of alleged resident to resident physical abuse between resident #003 and #004 it was noted through review of clinical documentation that there had been a previous incident of resident to resident abuse between the identified residents.

Review of clinical documentation indicated that on an identified date, a visitor advised a staff member that they had witnessed resident #004 punch resident #003 in the nose. Clinical documentation indicated a staff member found resident #003 with a small amount of clotted blood on the nose and on the hand.

Interview with the Director of Care(DOC) and Resident Care Coordinator(RCC) did not provide evidence that the alleged witnessed resident to resident physical abuse was investigated. [s. 23. (1) (a)]

2. Related to log 027390-15

The licensee has failed to ensure that appropriate action is taken in response to every such incident.

Clinical documentation indicated that a visitor reported to a staff member that they had witnessed resident #004 punch resident #003 in the nose.
The staff member found the resident with a small amount of clotted blood on the nose and hand.
Interview with the DOC and the RCC and further review of clinical documentation did not provide evidence that any action was taken to respond to the incident.[s. 23. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Related to 027390-15

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that has resulted in a physical injury the resident.

Related to the witnessed physical abuse by resident #004 directed towards resident #003.

Review of clinical documentation and interview with the DOC and RCC did not provide evidence that the Substitute Decision Makers for resident #003 and resident #004 were notified of the witnessed incident of resident to resident physical abuse. [s. 97. (1) (a)]

Issued on this 20th day of April, 2016

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

Original report signed by the inspector.