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 soins 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
Jun 2, 2016	2016_195166_0017	015773-16	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), SARAH GILLIS (623)

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): May 26, 27, 30 and May 31, 2916

Critical Incident Logs # 012803-16, 015083-16, 015549-16, 015773-16, 016641-16 related to alleged resident to resident physical abuse and log #011512-16 related to alleged staff to resident abuse were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers(PSW), Registered Nurses(RN), Registered Practical Nurses(RPN), member of the Behaviourial support Ontario (BSO), Resident Care Coordinator(RCC) and the Director of Care(DOC).
During the course of this inspection the inspectors observed resident to resident interactions, staff to resident interactions, review residents' clinical records, the licensee's investigation documentation and the licensee's policy Prevention, Reporting and Investigation of Abuse and Neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Related to log 015083-15

A critical incident(CIR) was received reporting an incident of alleged resident to resident physical abuse.
Review of the CIR and clinical documentation indicated that, RPN#104 , witnessed a co resident assisting resident #005. Resident #005 indicated being been pushed down by resident #004. Staff did not witness the incident and the co resident who assisted resident #005 was not able to give an account.
Resident #005 was assessed, no visible injuries were noted. Head injury routine was initiated. Resident #005, later complained of some discomfort.

Review of critical incident documentation and interview with the Director of Care and the Resident Care Coordinator, indicated the licensee was made aware of the alleged resident to resident physical abuse , the day after the incident had occurred.

The licensee's policy, Prevention, Reporting and Investigation of Abuse and Neglect ADM-01-03-05 directs all staff to immediately report any alleged, suspected or witnessed incidents of abuse to the appropriate supervisor on duty. If there are reasonable grounds to suspect that abuse has occurred or may occur, the home must immediately report to the MOHLTC.

RPN #104, who received the account of the incident from resident #005 did not immediately report the alleged incident of resident to resident abuse as per the licensee's policy. [s. 20. (1)]

Issued on this 2nd day of June, 2016

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

Original report signed by the inspector.