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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2017_687607_0023	024119-17	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

JULIET MANDERSON-GRAY (607)

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): December 13, 14 and 18, 2017

A Follow up inspection (Logs 017741-17, 017841-17) was completed concurrently during this Complaint Incident inspection (see inspection #2017_687607_0022) related to responsive behaviours and plan of care, specific to clear directions, non-compliance was identified for the Follow up inspection and was issued under inspection #2017_687607_0024.

A Critical Incident inspection (#2017_687607_0024) (Logs 016197-17, 022042-17, 023089-17, 028736-17, and 028915-17) was also completed concurrently during this Complaint inspection and non-compliance was identified under this report (Complaint report #2017_687607_0023) related to plan of care and was issued under the Critical Incident inspection (#2017_687607_0024).

In addition, the following Log was reviewed and inspected during this Complaint inspection:

Log #024119-17- regarding an alleged resident to resident abuse and resident care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinators (RCC), Director of Resident Programs and Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), families and residents.

During the course of this inspection, the Inspector reviewed clinical health records, observed staff to resident interactions, reviewed the homes investigations notes, reviewed the licensees specific policies related Resident Abuse Prevention, Responsive Behaviours and Management of Concerns/Complaints.

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.

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

Related to Log #024119-17 involving resident #014, #015 and #016:

A review of resident #016's clinical health records indicated that there were four incidents of resident to resident abuse that was directed towards resident #016 by resident #014 and #015 on three identified dates that were not investigated. (See WN #3).

During an interview with Resident Care Coordinator (RCC) #109 on an identified date, the RCC indicated that they do receive progress notes related to residents responsive behaviours via the LongTerm Care home electronic software, and further indicated these progress notes were being reviewed on a daily basis by the RCCs. There was no documented evidence to indicate that RNs in charge during these incidents had spoken to resident #016 to conduct an investigation. RCC #109 indicated being aware of the above identified incidents involving resident #016, but did not speak with the resident in regards to them.

The RCC who was aware of alleged, suspected or witnessed incident of abuse directed towards resident #016 by resident #014 and #015, did not ensure they were immediately investigated, specifically related to the identified four incidents of abuse that occurred on four separate identified dates. [s. 23. (1) (a)]

WN #2: 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; an abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm.

Related to Log # 024119-17 involving resident #014, and #016:

During an interview with resident #016 on an identified date, indicated that resident #014 had been abusive towards him/her in the past, which resulted in an injury to the resident. Resident #016 also indicated that resident #015 removed interventions in place that would alert staff that when residents were entering resident #016's room and have thrown beverages at him/her twice. Resident #016 indicated not feeling safe in the home and further indicated the incidents involving resident #016 and #014 were reported to staff.

A review of resident #016's progress notes for a six month period in 2017 indicated the following:

On an identified date and time staff heard an altercation coming from the corridors and

went to investigate. Upon arrival, resident #016 was observed visibly upset and headed towards the exit. Later that shift, PSW #149 informed RPN #148 that resident #016 had injuries to the residents body part. The RPN assessed the resident and indicated that resident #016 was unable to identify the cause of the injuries.

On an identified date and time, PSW #145, reported to RPN #150 that resident #016 had indicated that the injuries the resident sustained four days prior, were caused by resident #014. The RPN reported this to RCC #109, who notified the Ministry of Health and LongTerm Care (MOHLTC), the Substitute Decision Maker (SDM) and the police.

Four days after the incident occurred, RN #145, who was in charge of the LongTerm Care home at the time of the incident, documented a late entry, indicating that on the date of the incident, the RN had entered resident #016’s room, and asked the resident how he/she obtained the injuries, but the resident was referring to incidents of the past. The RN further indicated the resident was unable to identify the cause of the injuries.

During an interview, RPN #148 indicated that on the date the incident occurred, he/she was in charge of the unit resident #016 resides, when he/she heard a commotion along the hallway and had gone to see what happened. The RPN indicated that resident #014 was observed by the room door, and resident #016 was observed to be visibly upset, but both residents were not together upon arrival. The RPN indicated it was his/her first time working on the unit, and was not aware of the past history of behaviours between resident #014 and #016. The RPN indicated that he/she learned of the injury to resident #016 later during the shift, and did perform an assessment of the injuries, but did not ask the resident of how the injuries were obtained. The RPN indicated that the incident was reported immediately to RN #145, who was in charge of the LongTerm Care home on the same day.

During an interview, RN #145 indicated he/she spoke with resident #016 at time of the incident, and the resident was visibly upset, but would not identify how the resident obtained the injuries. The RN indicated being aware of the previous history of abuse involving resident #014 and #015 that was directed towards resident #016, but did not have reasonable grounds to suspect that abuse had occurred to resident #016.

During an interview, RCC #109 indicated that they do receive progress notes related to resident behaviours through the home documenting software and review these notes on a daily basis. The RCC #109 indicated that he/she had followed up on the incident involving resident #016 four days later when he/she learned of the incident. The Resident

Care Coordinator indicated he/she had contacted RN #145 who was in charge of the LongTerm Care home when the incident occurred, and had asked what was done about the incident, and at that time, the RN #145 had indicated that resident #016 was not able to identify how he/she obtained the injuries. The RN documented a late entry progress notes related to the incident. Resident Care Coordinator #109 indicated that he/she had not spoken with resident #016 in regards to the above identified incidents. The RCC also indicated he/she spoke with RN #145, and the RN indicated he/she did not notify the on call manager or the Ministry of Health and LongTerm Care (MOHLTC) as the resident could not identify how the injuries were obtained.

The licensee failed to ensure that when RN #145 who was in charge of the LongTerm Care home on an identified date, was aware of an incident involving resident #016, where the resident was noted to be visibly upset, and later that same shift was found to have an injuries to a body part, had reasonable grounds to suspect that abuse had occurred to resident #016, and did not immediately report the suspicion and the information upon which it was based to the Director, resulting in the incident not being reported to the Director until four days later. [s. 24. (1)]

2. For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Related to Log #024119-17 involving resident #014, #015 and #016:

A review of resident #016's progress notes for the period for a six month period in 2017, indicated there six incidents of either abuse/aggressions that were directed towards resident #016 by resident #014 and #015, which caused alarm or fear to resident #016.

There were also documented evidence over a three month period in 2017, to indicate that there were several instances where resident #016 expressed being fearful of sleeping at night, as a result of the incidents.

During interviews with resident #014 and #015, both could not recall having any altercations with any resident on the home area in the past.

During interviews with PSW #145, RPN #118 and RPN # 119, all indicated that both

resident #014 and #015 can appreciate the consequences of their actions.

During an interview, RCC #109 indicated that they do receive progress notes related to resident behaviours via the LongTerm Care home electronic software, and further indicated these progress notes were being reviewed on a daily basis by the RCCs. There was no documented evidence to indicate that RNs in charge of the building during these incidents had spoken to resident #016 to perform an investigation or report the incidents. RCC #109 indicated that he/she was aware of the above identified incidents involving resident #016, but did not speak with the resident in regards to them. RCC #109 also indicated the incidents were not reported to the Director because both resident #014 and #015 had diagnoses which include cognitive impairment.

The RCC who had reasonable grounds to suspect abuse of resident #016 had occurred or may have occurred, immediately report the suspicion and the information upon which it was based to the Director, specifically related to resident #016 had several incidents of threatening or intimidating gestures, actions, behaviours or remarks that caused an alarm or fear to the resident directed towards her by resident #014 and #015 who staff indicated can appreciate the consequences of their actions, were not reported to the Director immediately. [s. 24. (1)]

Issued on this 9th day of February, 2018

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

Original report signed by the inspector.