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 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
Aug 8, 2018	2018_594624_0011	003178-18	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

BAIYE OROCK (624)

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): June 28, July 3, & 4, 2018

The following complaint log was inspected:
Log #003178-18 related to a number of care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), a Registered Nurse (RN), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspector reviewed both electronic and hard copy health records as well as relevant policies and procedures related to continence care and bowel management, nutrition and hydration, and skin and wound.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan.

Complaint log #003178-18 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date. According to the submitted complaint, the complainant indicated a number of care concerns related to resident #001. The complainant also submitted video footage of resident #001 for three consecutive dates in a specified month and year.

Resident #001 was admitted into the home on an identified date with a range of medical diagnosis. Resident #001 was sent to hospital a day after the three consecutive dates for which video footage was provided, for a specified concern.

In a pre-inspection interview with Inspector #624, the complainant indicated that they would like the video footage to be reviewed as the resident did not receive a specified intervention during an identified period of time.

As a result of the number of care concerns raised by the complainant and the submitted video footage, a review was completed of resident #001's plan of care active at the time.The plan of care indicated that the resident required a specified intervention to be provided at identified intervals by staff. The plan of care directed staff to provide another specified intervention at identified intervals and provide care as needed.

A review of the video footage of resident #001 was completed by Inspector #624. This review indicated that during an identified time period and date, the resident was not observed to receive neither the first nor the second specified intervention at the identified intervals as directed in the resident's written plan of care.

Several separate interviews were carried out by Inspector #624 on two specified dates with PSWs #104, #108 and #109 who had worked on the identified day of video footage review, a day the resident was observed not to have received care as specified in their plan of care. All three PSWs indicated that it is the expectation of the licensee that care be provided to residents as specified in the residents' plan of care. All three PSWs indicated they could not recall what specific care they may have provided to resident #001 on the said day.

Another concern raised by the complainant was that staff did not take the time to feed the resident and would indicate that the resident refused, rather than try to feed the resident. As a result of this concern, a review of the Medication Administration Record (MAR) of resident #001 for a specified month was completed and it indicated an order to provide another specified intervention at identified times. A review of the licensee's monitoring

tool for the said intervention was completed over a nine day period and it indicated that the said intervention was administered at identified times. However, none was administered during the time period the intervention was ordered to be administered.

In separate interviews with RPNs #105, #107, RN #106 and Resident Care Coordinator (RCC) #103, all indicated that it is the licensee expectation that care be provided to residents as specified in the residents' plan of care. Regarding the third intervention, after reviewing the monitoring tool for the nine day review period stated above, RN #106 indicated that the intervention was administered at identified times and not on the identified time period in the order. The RCC #103, after reviewing the monitoring tool, indicated that the expectation is that care will be provided as in the plan of care and stated that it was difficult to understand the monitoring tool. Regarding the video footage for the first two specified interventions, the RCC declined viewing the video but indicated that it was difficult to tell if the resident had refused to receive the interventions that were specified in their plan of care.

After reviewing the video footage with the Director of Care (DOC) and the Assistant Administrator, the DOC confirmed that, resident #001 received the second specified intervention one time and not at the identified intervals as specified in the resident's plan of care. Regarding the first specified intervention that also needed to be provided at specified intervals, the DOC indicated that, while resident is seen to be in a specified position throughout the review period, it was impossible to know if the resident had refused care.

The licensee therefore failed to provide a specified intervention at an identified time as ordered, as well as failed to provide two specified interventions at identified intervals, as specified in the resident's plan of care.

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.