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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2013	2013_195166_0011	000889,001006,001007,001138	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)

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): February 12, 2013

During the course of the inspection, the inspector inspected four critical incidents:
Log #000889-12, 001006-12, 001007-12 and 001138-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, the Director of Care, the Resident Care Coordinator and the RAI Coordinator.

During the course of the inspection, the inspector(s) observed residents, reviewed residents' clinical health care records and the licensee's investigation documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Log O-001007-12 (critical incident #M522-000054-12).
The critical incident documentation and the licensee's investigation documentation indicates that a personal support worker transferred resident #3 without the assistance of a second staff member and then left the resident unattended. [s. 3. (1) 4.]

2. Log O-000889-12 (critical incident M522-000048-12).
The critical incident report, the clinical documentation and the licensee's investigation documentation reports that resident #1 was found on the floor. The registered nurse (RN) assessed the resident and identified the resident was experiencing pain on movement. The RN instructed a personal support worker to remain with the resident. The RN then left the area to give the shift report to the oncoming RN.
The licensee's investigation documentation indicates,the registered staff was not in attendance to monitor the resident's status. The resident was transferred to the hospital for further treatment. [s. 3. (1) 4.]

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 the licensee shall ensure that every resident has a right to be properly cared for in a manner consistent with his or her needs., to be implemented voluntarily.

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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Log O-001007-12 (critical incident #M522-000054-12).
The critical incident report, clinical documentation and the licensee's investigation confirm a health care aide left resident #3 unattended contrary to the resident's plan of care. The MOHLTC was not notified of this incident within the legislated time frame.

Log O-000889-12 (critical incident M522-000048-12) the critical incident report, the clinical documentation and the licensee's investigation documentation confirms a member of the registered nursing staff did not provide care according to the needs of resident #1 who had fallen and sustained an injury.
The MOHLTC was not notified of this incident within the legislated time frame. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Resident #3, plan of care designates the resident requires two staff and a mechanical lift to transfer safely. On an identified date resident #3 was transferred with one staff member using the mechanical lift. [s. 36.]

Issued on this 28th day of February, 2013

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