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
Apr 15, 2014	2014_365194_0001	O-000244-14	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), CAROLINE TOMPKINS (166), GWEN COLES (555), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 31, 2014, April 01, 02 ,03, 04, 07 & 08, 2014.

Concurrent to the Resident Quality Inspections the following Critical Incident Logs were inspected, Log #000235-14, #000199-14,#000903-13, #000964-13, #000762-13, #000773-13, #000253-13, #000254-13 and #000611-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW),

Dietitian, Environmental Service Manager (ESM), Physiotherapist (PT), Activity Adjuvants, Infection Control Nurse, Pain/Admission Nurse, Families, Residents, Family Council President, Resident Council President, Volunteer Coordinator, Director of Programs and Therapies, Supervisor of Programs, Food Services Director, Professional Practice Lead, Behavioural Support Ontario (BSO), Residents and Families.

During the course of the inspection, the inspector(s) toured the home, reviewed clinical health records , maintenance logs, staff education and training records, Resident and Family council minutes, Pharmacy and Therapeutics minutes, Immunization records, Medication incident reports, Internal incident reports, Critical incident reports and internal investigation for allegation of abuse. Reviewed home's policy "Responsive Behaviour Prevention and Management Program" NUR-04-08-10; "Abuse & Neglect-Prevention, Reporting & Investigation" ADM-01-05-01; "Pain Management Program" MED 03-01-07; "Infection Control Program" IC-05-01-01; "Visiting Animal Program" REC/VOL-07 -01-08; "Tuberculosis Screening" IC-05-05-06; "Resident Immunization & Consent Forms" IC-05-05-03; "Isolation/Additional Precautions-Contact, Droplet & Airborne" IC-05-03-02; "Medication Incident Report" 9-1; "High Alert Medications" 10-5; "Narcotic and Controlled Medications" 6-1; "Surplus and Discontinued strip-pack Medication Destruction" 12-12; "Drug Destruction and Disposal" 5-4; "High Alert Medications: Fentanyl Transdermal system" NUR-04-04-53; Skin and Wound Care Program INTERD-10-02-01; "Continence Care and Bowel Management Program" NUR-04-03-12. Observed dining service, medication administration, infection control practices, therapy services, activation programs, resident to staff interaction during the provision of care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee failed to comply with LTCHA 2007, s.6(1)(a) when the written plan of care for Resident #440 did not set out planned care related continence care.

Resident #440 was admitted to the hospital on an identified date and returned to the home 5 days later. Progress notes indicated Resident #440 returned with a change in continence care.

The written care plan relating to ADL's (toileting) and CCL's in place on return from hospital was reviewed. The care plan indicated "frequently incontinent" – resident is no longer toileted, total assistance of two staff to change brief. The care plan did not indicate the change in continence care.

RN #102 indicated in an interview that the care plan should have been updated upon return from hospital indicating the change in continence care.

Resident Care Coordinator (#115) indicated that the care plan for Resident #440 should have been updated on return from hospital.

The care plan did not set out planned care for staff or others who provide care, as it did not indicate the change in continence care. [s. 6. (1) (a)]

2. The licensee failed to comply with LTCHA 2007, s. 6(7) when the care set out in the plan of care for Resident #338 was not provided to the resident as specified in the plan.

Resident #338 has functional loss of right upper extremities and left hand is indicated at risk of further loss in Range of Motion (ROM).

Physiotherapy Quarterly Assessment, indicated that Resident #338 would benefit from continued Physio Therapy (PT) 2 to 3 times a week, is on a ROM program and is at further risk of decreased ROM and potential skin care issues.

Physiotherapy documentation records for the period of six months, indicated physiotherapy was provided on the following dates:
-6th month – 1 day = 10min, another day = 15min, another day = 15min
-5th month – 1 day = 15min, another day = 15min
-4th month – 1 day = 15min

-3rd month - no evidence of PT provided
-2nd month – 1 day = 10min
-1st month - no evidence of PT provided

Physio Therapist indicated awareness that Resident #338 had received PT only 1-2 times per month during the period reviewed. [s. 6. (7)]

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 ensuring that the plan of care for resident's
-with continence care, set out planned care for staff and others who provide care
-with physiotherapy are provided care as set out in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 13 when every resident bedroom occupied by more than one resident did not have sufficient privacy curtains to provide privacy.

Sufficient privacy curtain was not provided at the bed of each resident in Rooms:
D6 – occupied by two residents, specific to resident #422, missing end and middle panel;
D7 – occupied by two residents, specific to resident #432, missing panel between beds and 2 foot panel at wall;
E2 – occupied by two residents, specific to resident #427, missing panel between beds;
E5 – occupied by two residents, specific to resident #354, missing 2 foot panel at wall;
E9 – occupied by two residents, specific to resident #375, missing 2 foot panel at wall;
LK103 – occupied by two residents, specific to resident #357, missing panel between beds, and end of bed. [s. 13.]

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 ensuring that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 51(2)(a) when Resident #440 who is incontinent did not receive an assessment that, includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #440 returned from hospital on an identified date with a change in continence care.

Physician's orders on an identified date for Resident #440 directed treatment related to continence care.

The written care plan for Resident #440 upon return from hospital indicated the resident as being 'frequently incontinent' and requiring total assistance of two staff for brief changes. The care plan did not indicate the change in continence care.

A review of the progress notes, MDS-RAI and care plan for Resident #440, for the identified period did not indicate a reason for the change in continence care nor specific interventions relating to care.

RN #102 indicated that continence assessments are not usually done on re-admission to the home from hospital as the doctor had assessed the resident's needs. Staff #102 indicated continence assessment is done on admission and is not currently completed quarterly or with a change in continence level.

RCC #115 indicated "continence assessment tools should be completed on admission, quarterly and with change in status".

The home's policy 'Continence Care and Bowel Management Program' (NUR-04-03-12), directs that the home will collaborate with the resident or substitute decision maker to conduct an interdisciplinary assessment of bowel and bladder continence using a clinically appropriate tool: on admission, quarterly and when there is a change in condition that may affect bladder and bowel continence.

A continence assessment tool was noted on file for Resident #440 on admission to the home. There is no evidence of continence assessment being completed on an identified date, when a change in continence was indicated nor 5 weeks later when

the continence care changed again. [s. 51. (2) (a)]

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 by ensuring that each resident who is incontinent receives an assessment, and that when circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Log #000235-14:
The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified.

Clinical documentation indicates that Resident #06 has a history of making inappropriate sexual comments, being socially inappropriate and sexual touching of co- residents.
On an identified date, Resident #06, in a common area of the home was found sexually touching a co-resident. Resident #06 was redirected and told not to touch other residents
On another identified date, Resident #06 was observed in the common area of the home sexually touching a co-resident. Resident #06 was redirected and asked to step away from the resident.
After being redirected, Resident #06 was socially inappropriate towards co-residents.

Clinical documentation indicates that Resident #06 has a history of making inappropriate sexual comments and being socially inappropriate.

Interview with Registered and Personal Support staff confirm that behavioural triggers have not been identified. [s. 53. (4) (a)]

2. Log #000235-14
The licensee failed to comply with O. Reg. 79/10 s.53(4)(b) when strategies for Resident #06 were not developed and implemented to respond to the resident's demonstrated responsive behaviours.

Review of Resident #06's plan of care, clinical documentation, and interviews with registered staff and personal support staff indicate that strategy implemented to respond to the resident #06's responsive behaviour when socially inappropriate, is to remove resident from the public area when behaviour is disruptive or unacceptable and provide privacy. The plan of care, clinical documentation, and interviews with registered staff and personal support staff indicate that Resident #06 has a history of making sexual comments and has been involved in two incidents of inappropriate sexual touching with co-residents. There is no evidence that strategies have been developed or implemented to respond to these responsive behaviours. [s. 53. (4) (b)]

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 by ensuring that resident's demonstrating responsive behaviours
-will have triggers identified
-strategies developed and implemented to respond to the behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee failed to comply with O. Reg. 79/10 s. 229(4) when staff did not participate in the implementation of the Infection Prevention and Control Program.

During the dining observation of the lunch meal on an identified date, RPN #100, was observed not performing hand hygiene while administering medications before or after residents.

During a medication administration observation on an identified date, RPN #300, was observed not performing hand hygiene while administering medications (before or after residents - #005, #009 and #366), before and after performing blood glucose testing (resident #016) and before and after administering eye drops (resident #009).

During the medication administration observation, on an identified date, RPN #300 was observed handling medications (tablets and capsules) with her hands.

RCC #115 indicated that hand hygiene is an expectation between residents while administering medications and further indicated that registered staff are not to be handling medications with their bare hands. RCC indicated that RPN #300 had education relating to Hand Hygiene. [s. 229. (4)]

2. The licensee failed to comply with O. Reg. 79/10 s. 229(10)3. when there was no evidence that residents where offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Interview with Infection Control RN #123 on April 04, 2014 stated that immunization is offered to all new residents during admission. The Admission RN #126 reported a progress note related to admission will show if immunization has been given, refused or to be given. RN #126 stated the offering of, tetanus/diphtheria is recorded on log book on each unit. The RN #126 stated if information is not in the health record then it should be in log book.

Review of Health records and unit log books for Resident #432, #435 and # 437 did not provide any evidence of being offered immunization for tetanus and diphtheria. [s. 229. (10) 3.]

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 ensuring that all staff participate in the implementation of the Infection Prevention and Control Program and residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s.37(1)(a)when resident's personal items, were not labeled within 48 hours of admission and of acquiring, in the case of new items.

Room #A123 – two combs, and a safety razor observed not labeled in the washroom; this is a shared washroom (semi room)
Room #A106 – two toothbrushes and a comb observed not labeled in the washroom; this is a shared washroom (semi room)
Room #A105 – a toothbrush sitting in a bottle of mouthwash, a specimen collection measuring device sitting on the back of the toilet and a bar soap sitting on the sink, all items were unlabeled; this is a shared washroom (semi room)
Room #B108 – three hair brushes observed not labeled in the washroom; this washroom is shared with the adjoining room
Room #B115 – a urinal unlabeled and sitting on the back of the toilet; this washroom is shared with the adjoining room.
Room #B101 – a urinal and specimen collection measuring device unlabeled and sitting on the back of the toilet; this is a shared washroom (semi room)
Room #B111 – a specimen collection measuring device sitting on the back of the toilet and a bar soap sitting on the sink, items were not labeled, this washroom is shared with the adjoining room.
Room #B113 - a specimen collection measuring device sitting on the back of the toilet and a bar soap sitting on the sink, items were not labeled, this washroom is shared with the adjoining room.

RCC #115, indicated that she was not aware that urinal's and specimen collection containers' were to be labeled. RCC indicated that urinals, bedpans and specimen collection containers are for individual resident use and left in the resident washrooms. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Log #O-000964-13:
The licensee failed to comply with LTCHA, 2007 s.76(4) by ensuring that all staff have received retraining annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.
The Administrator confirmed that Staff members #139, 140 and 141 did not receive annual retraining in 2013 regarding zero tolerance of abuse and neglect of residents.
Review of training records for 2013 confirmed no abuse training recorded for said staff members. [s. 76. (4)]

Issued on this 17th day of April, 2014

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

Chantal Lafrenière (194)