Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 25, 2010	2010_157_9522_25Aug115046	Critical Incident M522-000041-10 Log #0-000935

Licensee/Titulaire
Regional Municipality of Durham, 605 Rossland Rd.,East, Whitby, ON L1N 6A3 Fax: (905)668-1567

Long-Term Care Home/Foyer de soins de longue durée
Fairview Lodge, Fairview Lodge, 632 Dundas St. West, PO Box 300, Whitby, ON L1N 5S3 Fax: (905)668-8934

Name of Inspector(s)/Nom de l'inspecteur(s)

Pat Powers, #157

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection (CI #M522-000041-10) related to a resident falling from her bed.

During the course of the inspection, the inspector spoke with the Director of Care, one Registered Nurse (RN), one Registered Practical Nurse (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed the location of the incident, bed surface used before and following the incident, the resident's clinical records (written care plan, nursing progress notes, home's internal incident report)

The following Inspection Protocol was used during this inspection:
Fall Prevention IP

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s.6(7):

(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:

The following care directives in the in the plan of care for a resident were not provided by staff in the provision of care on August 7, 2010:

1. Personal Hygiene – the care plan directs that the total assistance of two staff is required to do all aspects of care for the resident – on August 7, 2010 one PSW was washing the resident.
2. Bed Mobility –the care plan directs that the resident requires total assistance of 2 staff to turn and reposition her – on August 7, 2010 the resident was turned on her side to be washed, by one PSW.
3. Falls Risk – the care plan directs that the resident is to have 2 side rails up at all times when in bed and two staff to provide all care – on August 7, 2010, the above noted PSW who was alone with the resident, left the resident unattended to investigate an altercation between two other residents in the corridor, The resident was left unattended with her siderail down.

Inspector ID #:	157

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

WN #2: The Licensee has failed to comply with O.Reg. 79/10, Section 36:

Transferring and positioning techniques

36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. On August 7, 2010, the resident was left unattended on her side, resulting in her falling out of the bed when a PSW left her to respond to an altercation between two other residents in the corridor.
2. On August 7, 2010, two staff members were not present to position the resident.

Inspector ID #:	157

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 staff use safe transferring and positioning devices and techniques when assisting this resident. This plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	**Date of Report:** (if different from date(s) of inspection). October 8. 2010