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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2014	2014_293554_0030	O-000673-13	Critical Incident System

Licensee/Titulaire de permis

CITY AND COUNTY OF PETERBOROUGH
881 Dutton Road PETERBOROUGH ON K9H 7S4

Long-Term Care Home/Foyer de soins de longue durée

FAIRHAVEN
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

KELLY BURNS (554)

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): July 23-25 and July 28-29, 2014

The following Log(s), #O-000327-13, O-000463-13, O-000483-13, O-000543-13, and O-000673-13 were inspected

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Resident Care(DRC), Resident Care Manager(s), Registered Nurse (s), Registered Practical Nurse(s), Personal Support Worker(s), Residents, and Family

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Related to Log #O-000464-13, for Resident #006:

The home failed to comply with O. Reg. 79/10, s. 8 (1)(b), by ensuring where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, specific to Falls Prevention is complied with.

The home's policy, Falls Prevention (RCM-N-410) directs that the Registered Nurse will complete a Falls Risk Assessment Tool on admission, with any change in resident status and following a fall. The policy further directs registered staff to initiate and or update the plan of care to address residents identified as at risk for falls.

Resident #006 was admitted to the home on a specific date according to information supplied to the home by both the Community Care Access Centre and the family, resident was known to be at risk for falls.

Progress notes and Risk Management Incident(s) reviewed for a specific time period indicated Resident #006 fell several times during this time period.

A review of clinical health records for Resident #006 failed to provide evidence that a Falls Risk Assessment was conducted upon:

- Admission, nor following specific falls incidents.

There is no evidence that the plan of care was updated to identify that Resident #006 was at risk for falls.

The Executive Director and the Director of Resident Care both indicated that the Falls Risk Assessment should have been completed on admission and with each fall, in addition to the care plan identifying Resident being at risk for falls. [s. 8. (1) (a),s. 8. (1) (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 to ensure there is a process in place to monitor that the home's policy specific to: Falls Prevention is complied with as it relates, to completing falls risk assessment tools and updating of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to Log #O-000327-13, for Resident #007:

The licensee failed to comply with LTCHA, 2007, s. 20 (1) by ensuring that the policy to promote zero tolerance of abuse of a resident is complied with.

Resident Care Manager contacted MOHLTC to report an incident of Abuse (Staff to Resident) which had occurred.

Details of the incident were as follows:
- Resident #007 declined to have care on a specific date, indicating the reason for the refusal. The report indicates Staff #100 failed to abide by the request of the resident. Resident #007 and another staff member indicated that Staff #100 told resident that care procedure was occurring, then grabbed Resident #007 and placed resident into a chair. Resident #007 indicated telling staff several times that the care was being refused; resident indicated not being able to stop Staff #100.
- Resident #007 indicated being handled roughly by Staff #100.

Staff #107 indicated hearing Resident #007 on two occasions decline care. Staff indicated witnessing Staff #100 grab resident and place resident into a chair, despite resident's wishes.

Staff indicated that this was not the first incident in which Staff #100 mistreated Resident #007.

Staff #107 did not report either of the abusive incidents.

Resident Care Manager(RCM) indicated knowing of the incident as of the date in which incident was brought forward by a Registered Practical Nurse. RCM indicated speaking at that time to Resident #007, resident's Personal Attorney for Care, and contacting both employees involved to arrange meeting times. RCM indicated staff were placed on a leave pending the outcome of the investigation.

The first interview with employee's involved involved with the allegation took place three days after the date in which it was reported.

The Human Resources Manager indicated educational records did confirm Staff #100 and #107 as having had annual training with respect to Abuse Prevention.

Human Resources Manager indicated that staff #107 may have been fearful in coming forward to report the concern.

The home's policy Zero Tolerance of Abuse and Neglect (RCM-RR-590) directs that all staff of Fairhaven MUST report any act of Resident Abuse to their supervisor. [s. 20. (1)]

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 there is a process in place to monitor that all staff are aware of the home's policy with respect to Zero Tolerance of Abuse and are reporting any act of Resident Abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

s. 24. (10) When the care plan is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the care plan. O. Reg. 79/10, s. 24 (10).

Findings/Faits saillants :

1. Related to Log #O-000464-13, for Resident #006:

The licensee failed to comply with O. Reg. 79/10, s.24(2) by the 24-hour admission care plan must identify the resident and must include, at minimum, the following with respect

to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling and interventions to mitigate those risks.

According to information contained in the Community Care Access Centre information package(s) provided to the home Resident #006 had sustained several falls prior to admission.

A review of the clinical health record indicated, family of Resident #006 told staff during the admission interview that resident had fallen at home several times during the past months.

Progress notes, written by registered nursing staff, detail resident having a fall and sustaining an injury post admission.

The written plan of care failed to identify Resident #006 as being at risk for falls, nor did it identify strategies in place to prevent or reduce resident's risk of falls.

The Executive Director, as well as the Director of Resident Care both indicated the plan of care should have identified the falls risk for this resident. [s. 24. (2)]

2. Related to Log #O-000464-13, for Resident #006:

The licensee failed to comply with O. Reg. 79/10, s.24(9)(a), by ensuring that the resident is reassessed and the care plan is reviewed and revised when, the resident care needs change, specific to falls prevention and management.

Progress Notes reviewed for the period identified document Resident #006 having sustained a fall on specific dates, a number of the falls resulted in injury or complaints of discomfort.

The plan of care reviewed for period indicated above failed to identify Resident #006 being a falls risk or any revisions made to the resident's care plan to reduce or eliminate the falls risk or strategies to mitigate risk to this resident.

The Director of Resident Care indicated the plan of care should have been reviewed and revised as necessary following a resident falling.

Resident #006 no longer resides at the home. [s. 24. (9)]

3. Related to Log #O-000464-13, for Resident #006:

The licensee failed to comply with O. Reg. 79/10, s.24(10), by ensuring when the plan of care is being revised because the care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the care plan.

Resident #006 sustained a number of falls, during a one month period; some of the falls resulted in injury to resident.

Progress Notes indicate the Physiotherapist assessed Resident #006 on a specific date indicating the following recommendations in an effort to reduce resident falls:
- initiate a toileting schedule
- placement of a personal wheelchair seat alarm
- increase monitoring of resident by nursing staff

A review of the written care plan for the above period failed to identify that the recommendations by the Physiotherapist were implemented.

Staff #109 indicated Registered Practical Nurse is usually responsible to update the care plan following recommendations made by the Physiotherapist. [s. 24. (10)]

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 there is a process in place to monitor that the 24-hour admission care plan identifies resident risk specific to falls risk and strategies to mitigate those risks; the licensee will further ensure there is a process in place to ensure residents are reassessed and the plan of care revised when the care needs of the resident changes or when the plan has been ineffective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to Log #O-000327-13, for Resident #007:

The licensee failed to comply with O. Reg. 79/10, s.98, by ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident.

Resident #007 reported an interaction of Abuse (Staff to Resident) to Staff #108. Staff reported the incident to Resident Care Manager. The details of the incident are as follows:
- Resident #007 indicated incident occurring on the day earlier. Resident indicated refusing care
- Resident indicated that despite refusing care, Staff #100 told resident that care would be occurring
- Staff #100 grabbed resident roughly, pulled resident out of bed and placed resident into a chair in preparation for care
- Resident indicated being unable to stop Staff #100 during the interaction
- Resident indicated that this was not the first interaction of this sort with Staff #100

A Critical Incident Report pertaining to Abuse was reported to MOHLTC.

The home did not report the incident of Abuse (Staff to Resident) to the police.

The home's policy Zero Tolerance of Abuse and Neglect (RCM-RR-590) directs that the home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the home suspects may constitute a criminal offence. [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. Related to Log #O-000464-13, for Resident #006:

It is to be noted, O. Reg. 79/10, s. 107 (3) was amended September 15, 2013. The following denotes the regulation in effect at the time

The licensee failed to comply with O. Reg. 79/10, s.107 (3), by ensuring the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by a report under subsection (4):
4. An injury in respect of which a person is taken to the hospital

Interim Resident Care Manager, submitted a Critical Incident Report (CI) specific to a resident injury that resulted in a transfer to hospital, details of the incident are as follows:

Resident #006 was found on the floor; resident sustained injuries as a result of the fall.

According to the Critical Incident and related progress notes, Resident #006's health status continued to decline post fall; a decision was made to transfer resident to the hospital for assessment and treatment.

Resident was admitted to hospital; health continued to decline and later passed away.

The Critical Incident Report was not submitted by the home until approximately 10 days later. [s. 107. (3.1)]

2. Related to Log #O-000543-13, for Resident #005:

It is to be noted, O. Reg. 79/10, s. 107 (3) was amended September 15, 2013. The following denotes the regulation in effect at the time

The licensee failed to comply with O. Reg. 79/10, s.107 (3), by ensuring the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by a report under subsection (4):
4. An injury in respect of which a person is taken to the hospital

Resident Care Manager (#104) submitted a Critical Incident with regards to Resident #005, the details are as follows:

Resident was being assisted by staff; the report indicated resident lost balance and fell. Resident #005 sustained injuries as a result of the fall. Resident was transferred to the hospital for assessment and treatment of injuries.

The Critical Incident report was not submitted by the home until approximately 10 days later.

Both the Director of Resident Care and Resident Care Manager (#103) indicated they thought the time frame for notification of MOHLTC was ten days, for resident incidents involving an injury and transfer to hospital. [s. 107. (3.1)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.