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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2014; Jan 5, 2015	2014_292553_0035	O-001139-14	Resident Quality Inspection

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

MATTHEW STICCA (553), JOANNE HENRIE (550), MEGAN MACPHAIL (551), RENA BOWEN (549), SAMI JAROUR (570)

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): November 24,25,26,27,28 and December 1,2,3,4,5 2014.

During the course of the Resident Quality Inspection, the following Critical Incident Inspection Logs were also addressed : Logs O-000242-14, O-000422-14, O-000423-14, O-000541-14, O-000789-14 and O-000962-14.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Resident Care (DRC), Director of Finance and IT,Executive Assistant, Resident Care Manager (RCM), Nutrition Services Manager, Environmental Services Manager, Infection Prevention and Control Lead, RAI-Coordinator, Physiotherapist, Residents' Council President, Family Council Chair, Residents, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nutrition Services Worker (NSW),

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

14 WN(s)
3 VPC(s)
1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007 s.19 by failing to protect Residents #26, #21 and #22 from abuse and or neglect.

Definitions:
Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,"emotional abuse" means, (a)any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a)any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Under O. Reg. 79/10, s. 5 For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Resident #26:
Resident #26 requires the use of an assistive device for locomotion. On a specified date and time while in the dining room during dinner service, Resident #26 requested assistance from PSW S127 to pick up an item Resident #26 had dropped on the floor. PSW S127, who works full time in the home, responded in a loud and rude voice that Resident #26 needs to stop calling staff for assistance when they are busy serving and

feeding in the dining room. This was overheard by a registered staff member who was also in the dining room at the time.

Upon becoming aware of this occurrence the CEO came into the home on a specified date and began their investigation into this incident of verbal abuse. In review of the home's investigation, Resident #26 disclosed to the CEO that on "numerous occasions" Resident #26 had been left on the toilet by PSW S127 without giving Resident #26 the call bell. Three additional staff members confirmed this allegation to the CEO. PSW S127 was disciplined for these actions.

The incident that occurred on a specified date and time was not reported to the Director in accordance with legislative requirements. Additionally the incident(s) of Resident #26 being left on the toilet by PSW S127 without giving the call bell to Resident #26 was never reported to the Director. This was confirmed by the DRC who stated that they could not provide a reason as to why the incident on a specified date was not reported immediately or a reason as to why the home never notified the Director of the incident of neglect.

The licensee failed to comply with:
-LTCHA, 2007 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. (WN #7)
-LTCHA, 2007 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: 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. (WN #8)

Related to Resident #22:
On a specified date and time, Resident #22 reported the following: when PSW S135 was assisting Resident #22 with HS (bedtime) care PSW S135 called Resident #22 "lazy" and pulled back the bedding on the bed and told Resident #22 that they could get into bed on their own.
Interview with PSW S138 indicated on the same specified date, Resident #22 reported to PSW S138 "that worker made me feel useless" and pointed to PSW S135. PSW S138 told Resident #22 that they were not useless, you are a human being.
Interview with RN S134 indicated that on the same specified date, RN S134 was notified

of the incident and spoke to Resident #22. Resident #22 was very teary and was hurt by PSW S135's actions.
Resident #22's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on the same specified date. RN S134 who was in charge of the home at time of incident was made aware of the incident later on the same specified date. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the specified date that the incident occurred.
In a review of the home's policy, "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 revised: March 22, 2013), indicated that staff are to: "report any witnessed, suspected or alleged abuse to your Supervisor/Manager immediately". This action was not met by RN S134 who sent an email to RCM S131. RCM S131 read the email on three days after the incident had occured, which was the same day the licensee notified the MOHLTC of the incident.

During the course of the inspection, the POA for Resident #22 indicated that their loved one was very upset about the incident that happened on the evening of the specified date when PSW S135 called Resident #22 lazy. Resident #22's POA indicated a PSW informed her of the incident when she was visiting the next day and she was informed later by the RN.

The licensee failed to comply with:
-LTCHA, 2007 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. (WN #7)
-LTCHA, 2007 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: 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. (WN #8)
-O.Reg 79/10 s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision maker,if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. (WN #13)

Related to Resident #21:
On the same specified date as the occurrence involving Resident #22, Resident #21 was discovered sitting in their room calling for help with a very faint voice. PSW S135 who

assisted Resident #21 with a snack did not put back in place the required adaptive tool of Resident #21's assistive device for locomotion that holds the adaptive tool and a communication device required for Resident #21. Resident #21 was left in such a state that they were unable to communicate or move their assistive device for locomotion to seek out assistance. Resident #21 was left in that position for over 20 minutes.

The plan of care in effect at time of incident of on a specified date identified the following:
- for mobility interventions, Resident #21 is independent with assistive device for locomotion moved with an adaptive tool operated by the resident.
- for communication interventions, Resident #21 has a communication system that attaches to the assistive device for locomotion.

PSW S138 indicated that on the same specified date, PSW S138 assisted Resident #21 with their adaptive tool used to control his/her assistive device for lcomotion. Resident #21 was mad. PSW S138 apologized to Resident #21, Resident #21 indicated that it was not PSW S138's fault that he/she were left the way that they were.
RN S140 indicated when she spoke to Resident #21 the day after the incident occurred, Resident #21 was upset because PSW S135 left him/her in such a state that left him/her without control and feeling helpless.

Review of Resident #21's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on a specified date and time. RN S134 who was in charge of home at time of incident was made aware of the incident on the same specified date. During an interview during the course of the inspection, RN S134 indicated that the MOHLTC should have been notified and the manager on call should have been notified. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the date of the occurrence. Three days after the incident the licensee notified the MOHLTC of the incident.
It should be noted that on a specified date PSW S135 was involved in two incidences of abuse and or neglect involving two different residents, (Resident #21 and Resident #22). Inspector #570 and #553 reviewed the PSW staffing schedule for the time period around the incidences of abuse; during that time frame PSW S135 continued to work in the home. One day after the alleged incidents occurred, PSW S135 was working in the home for 7.33 hours, and two days after the alleged incidents occurred PSW S135 was working in the home for 7.90 hours. Three days after the alleged occurrences of abuse and or neglect RCM S131 was made aware of the transgressions of PSW S135 via an email sent by RN S134; PSW S135 was suspended pending investigation into the alleged allegations.

In an interview on during the course of the inspection the DRC stated to Inspector #553 that indeed PSW S135 worked in the home for the two days after being involved in two separate incidences of abuse and or neglect of a resident. However, PSW S135 was not working in the same resident care area as they were on the specified date when PSW S135 was involved in the two incidences with Resident #21 and #22. PSW S135 no longer is employed by the home.

The licensee failed to comply with:
-LTCHA, 2007 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 (WN #7)
-LTCHA, 2007 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: 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. (WN #8)
-LTCHA, 2007 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. (WN #6)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #26, #22 and #21, the following was also identified.
-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 (as identified in WN #10)

-The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and
the potential for abuse and neglect by those in a position of trust, power and responsibility
for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg.79/10, s. 96. (as identified in WN #12)

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes signed consent for the use of a restraint by either the Resident or if the Resident is incapable a Substitute Decision Maker (SDM) for Residents #4, #10 and #7

On a specfied date, Resident #4 was ordered two bed rails when in bed for positioning and mobility by a physician. On a later specified date, the physician ordered two full bed rails when in bed for safety.

Until a specified date after the order of two full bed rails when in bed for safety, a PASD Monitoring Record was completed. After that specified date, a Restraint Monitoring Record for two full side rails was initiated.

RN S118 reviewed Resident #4's heath care record and was not able to find documentation to support that Resident #4's SDM consented to the use of full bed rails as a restraint.

A progress note entry on a specified date stated that Resident #4 is ordered full bed rails at night, and that Resident #4's bed had been changed and now had half bed rails. On a specified date, Resident #4 was ordered half bed rails at night for safety by the physician. RN S118 stated that the half rails were considered to be a restraint. A Restraint Monitoring Record for two half side rails for safety remains in place at this time.

RN S118 reviewed Resident #4's heath care record and was not able to find documentation to support that Resident #4's SDM consented to the use of half bed rails as a restraint. [s. 31. (2) 5.]

2. On a specified date, Resident #10 was observed to be seated in a wheelchair with a seat belt applied. Resident #10 stated they were unable to release the seat belt.

Resident #10's health care record was reviewed. On a specified date a ten pound seat belt for safety was ordered by the physician.

A Restraint Monitoring Record was initiated on after the order was obtained, and Resident #10's care plan was updated to reflect that Resident #10 used a ten pound seat belt.

Resident #10's current care plan indicates the use of a seat belt for Resident #10.

RN S118 reviewed Resident #10's heath care record and was not able to find documentation to support that Resident #10's SDM consented to the use of a seat belt restraint. [s. 31. (2) 5.]

3. Throughout the course of the inspection, Resident #7 has been observed wearing a seat belt while in a wheelchair. During the observation period that occurred during the inspection, Resident #7 indicated twice to Inspector #551 that he/she was unable to release the belt.

Resident #7's health care record was reviewed. On a specified date, Resident #7 was ordered a front facing seat belt in wheelchair for safety. A Restraint Monitoring Record is in place and Resident #7's care plan confirms the use of a restraint. Inspector #551 was not able to find documentation to support that Resident #7 or their SDM consented to the use of a seat belt as a restraint.

During the inspection, the DRC provided a copy of a Least Restraint Assessment Form dated the specified day in which Resident #7 consented to the use of a seat belt and bed rail restraints. [s. 31. (2) 5.]

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 when restraining a resident by a physical device, that consent for use of the restraint has been obtained by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On a specified date Resident #8 was observed by Inspector #549 to have an opened area of altered skin integrity approximately 2 cm by 2cm. The observed area was covered with fresh blood, some dried blood, with some crusty outer areas that were dark in colour. The area also appeared to be raised and inflamed.

On a specified date Inspector #549 spoke with the unit RPN S110 who stated that Resident #8 has had the altered area of skin integrity for three years. RPN S110 stated to Inspector #549 that the area will get to a point of just about healing then it will start to bleed again and become inflamed. RPN S110 stated to Inspector #549 that the area has never healed completely since it appeared.

PSW S111 indicated to Inspector #549 during an interview that all PSW's are expected to inform the registered nursing staff if there is a change in the specific area on Resident #8 or if Resident #8 touches the area and causes it to bleed.

PSW S111 stated to Inspector #549 that Resident #8's area of altered skin integrity seems to "get better then it gets worse before it can heal and there are times when there is a lot of blood on Resident #8's face and pillow."

On a specified date during the inspection Inspector #549 reviewed the health care records for Resident #8, it was noted that a skin assessment using a clinically approved tool was last completed by a member of the registered nursing staff on more than five years ago. At that time it was indicated that Resident #8 had no altered skin integrity.

During the course of the inspection the DRC confirmed with Inspector #549 that the expectation is a member of the registered nursing staff complete a skin and wound assessment for Resident #8 who is exhibiting altered skin integrity using the home's Wound Management Assessment tool on Point Click Care. [s. 50. (2) (b) (i)]

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 when a resident is exhibiting an alteration in skin integrity, including skin breakdown, skin tears or wounds, that the resident receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is access to point-of-care hand hygiene agents.

It was noted by Inspector #551, #553 and #549 during Stage 1 of the Resident Quality Inspection, which occurred on November 24-26, 2014, that hand hygiene agents at point-of-care are not accessible.

Hand hygiene agent dispensers were accessible for use along each resident unit hallway outside of every fourth resident room until the end of the hallway where there is one dispenser for each of the two remaining rooms.

On a specified date during the inspection the Infection Prevention and Control Practitioner (IPACP) S108 confirmed with Inspector #549 that the home's hand hygiene program follows the evidence based "Just Clean Your Hands 4 Moments" hand hygiene model supported by Public Health Ontario. The IPACP S108 stated to Inspector #549 that the "Just Clean Your Hands Program" had been implemented in the home in 2009.

Following the Just Clean Your Hands program the Alcohol-Based Hand Rub (ABHR) is to be placed "within arm's reach of where care is provided to residents". The Just Clean Your Hands Program identifies that "providing ABHR at the point of care makes it easier for staff to clean their hands the right way at the right time".

During an interview during the inspection the IPACP S108 confirmed with Inspector #549 that having hand hygiene agents accessible at point-of-care is best practice when following the "Just Clean Your Hands Program" supported by Public Health Ontario. It was also confirmed by the IPACP S108 that personal hand hygiene agents are not carried by the front line staff for use as part of the home's hand hygiene program. Inspector #549 did not observe front line staff carrying personal hand hygiene agents during the inspection period.

The DRC confirmed during the inspection that the home does not have hand hygiene agents accessible at point-of-care as described by the Public Health Ontario Just Clean Your Hands Program.

On a specified date during the inspection the IPACP S108 indicated to Inspector #549 that the home has initiated a plan for the installation of hand hygiene agent dispensers for use at the point-of-care. [s. 229. (9)]

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 home continues to follow the hand hygiene program "Just Clean Your Hands" supported by Public Health Ontario by installing Alcohol-Based Hand Rub point-of-care dispensers as outlined in "Just Clean Your Hands", to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. [Related to Log O-000423-14]

The licensee has failed to ensure that residents' rights were fully respected and promoted in a way that fully recognized their individuality and dignity.

Review of a Critical Incident Report indicated on the evening of a specified date and time, Resident #22 reported the following: when PSW S135 was assisting Resident #22 with HS (bed time) care PSW S135 called Resident #22 "lazy" and pulled back the bedding on the bed and told Resident #22 that they could do the rest on their own.

Interview with PSW S138 indicated on a specified date Resident #22 reported to PSW S138 "that worker made me feel useless" and pointed to PSW S135. PSW S138 told Resident #22 that they were not useless, you are a human being.

Interview with RN S134 indicated that on a specified date and time, RN S134 was notified of the incident and spoke to Resident #22. Resident #22 was very teary and was hurt by PSW S135's actions. When Resident #22 called for help, PSW S135 called him lazy.

In an interview that occurred during the course of the inspection the POA for Resident #22 indicated that their loved one was very upset about the incident when PSW S135 called Resident #22 lazy. Resident #22's POA indicated a PSW informed her of the incident when she was visiting the next day and she was informed later by the RN. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has a right to have his or her personal health information with the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

During an observation of the medication pass, Inspector #550 observed RPN S121 disposing of the resident's empty medication pack containing personal information in the garbage attached to the medication cart. Inspector #550 observed many opened discarded empty medication packs in this garbage. Inspector #550 retrieved 3 packs for different residents and observed the personal health information still being on the

medication pack:

Resident #23, in a specific room number: a specific oral dietary supplement to be taken Tue Dec 02, 2014 at 12:00.
Resident #24, in a specific room number: a specific mood stabilizer and anti-epileptic agent, to be taken Tue Dec 02, 2014 at 12:00.
Resident #25, in a specific room number: a specific stool softener, a specific synthetic hormone, a specific vitamin supplement, a specific direct Xa inhibitor to be taken Tue Dec 02, 2014 at 12:00.

During an interview, RPN S121 indicated to inspector all empty medication packs, bottles and pill cards are disposed of in the regular garbage without any resident's personal health information being removed.

During an interview, the DRC indicated to Inspector #550 she was unsure what the home's policy was regarding the disposal of the empty medication packs containing personal health information. She indicated it is the home's expectation that staff follow the policy in the pharmacy's policy and procedure manual.

Inspector #550 reviewed the home's Medication Pass policy, Policy #3-6 from Medical Pharmacies policy and procedure's manual. The policy indicated under procedure 14. "Empty strip pouches can be destroyed with water to remove information and placed into the garbage or shredded (PIPEDA)".

As of December 4, 2014, it was observed that the home had begun to place empty strip pouches in a container with water to remove the personal health information provided on the strip pouches. [s. 3. (1) 11. iv.]

WN #6: 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 :

1. [Related to Log O-000422-14]

The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #21 as specified in the plan.

Review of a Critical Incident Report indicated on a specified date and time Resident #21 was discovered sitting in their room calling for help with a very faint voice. PSW S135 who assisted Resident #21 with a snack did not put back in place the required adaptive tool of Resident #21's assistive device for locomotion that holds the adaptive tool and a communication device required for Resident #21. Resident #21 was left in such a state that they were unable to communicate or move their assistive device for locomotion to seek out assistance. Resident #21 was left in that position for over 20 minutes.

The plan of care in effect at time of incident of on a specified date identified the following:
- for mobility interventions, Resident #21 is independent with assistive device for locomotion moved with an adaptive tool operated by the resident.
- for communication interventions, Resident #21 has a communication system that attaches to the assistive device for locomotion.

During the course of the inspection, Inspector #570 had an interview with the Physiotherapist which indicated that: Resident #21 was independent in mobility and was able to effectively communicate as long as the interventions outlined in the care plan were in place. If not, Resident #21 would be completely dependent on staff.

On a specified date during the course of the inspection, Inspector #570 held an interview with PSW S136 and PSW S137 which indicated that Resident #21 used an adaptive tool to control his/her assistive device for locomotion. If the adaptive tool is moved away to feed Resident #21, it has to be then put back in place so the communication system can work. If the communication system was not in place, we could not hear him/her outside of his/her room.

PSW S138 indicated that on the same specified date, PSW S138 assisted Resident #21 with their adaptive tool used to control his/her assistive device for lcomotion. Resident #21 was mad. PSW S138 apologized to Resident #21, Resident #21 indicated that it was not PSW S138's fault that he/she were left the way that they were.

RN S140 indicated when she spoke to Resident #21 the day after the incident occurred, Resident #21 was upset because PSW S135 left him/her in such a state that left him/her without control and feeling helpless. [s. 6. (7)]

WN #7: 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 Logs O-000962-14 (Resident #26), O-000423-14 (Resident #22) and O-000422-14 (Resident #21).

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.

Related to Log # O-000962-14 and Resident #26:

Inspector #550 reviewed a critical incident report that was submitted to the Director by the home. As per the critical incident report, Resident #26 is in a assistive device for locomotion because of a medical condition. On a specified date the resident requested assistance from PSWS127 to pick up an item Resident #26 had dropped on the floor in the dining room at supper time. PSW S127 responded in a loud and rude voice that Resident #26 needs to stop calling staff for assistance when they are busy serving and feeding in the dining room.

In review of the home's policy "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 Revised: March 22, 2013). This policy directs staff to complete the following: "5. In the event of any alleged incident of Resident abuse, the individual will notify Ministry of Health and Long-Term Care. The Resident Care Manager will submit a Critical Incident Report within 10 days or earlier date if required by Senior Manager."

The incident that occurred on a specified date and time was not reported to the Director in accordance with legislative requirements. Additionally, during an interview the DRC indicated to Inspector #550 the incident should have been immediately reported to the Director.

Related to Log #O-000423-14 (Resident #22)

Review of Critical Incident Report indicated on the evening of a specified date and time, Resident #22 reported the following: when PSW S135 was assisting Resident #22 with HS (bed time) care PSW S135 called Resident #22 "lazy" and pulled back the bedding on the bed and told Resident #22 that they could do the rest on their own. Interview with PSW S138 indicated on a specified date Resident #22 reported to PSW S138 "that worker made me feel useless" and pointed to PSW S135. PSW S138 told Resident #22 that they were not useless, you are a human being.

Interview with RN S134 indicated that on a specified date and time RN S134 was notified of the incident and spoke to Resident #22. Resident #22 was very teary and was hurt by PSW S135's actions. When Resident #22 called for help, PSW S135 called him lazy.

In review of the home's policy "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 Revised: March 22, 2013). This policy directs staff to complete the following: "Report any witnessed, suspected or alleged abuse to your Supervisor/Manager immediately."

RN S134 who was in charge of the home at time of incident was made aware of the incident on the date of occurrence. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the same date. RCM S131 did not see the email until three days after the occurrence, the same day the licensee notified the Director of the incident. RN S134 failed to comply with policy RCM-RR-590.

In review of the home's policy "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 Revised: March 22, 2013). This policy directs staff to complete the following: "Upon Fairhaven becoming aware of other alleged, suspected, or witnessed incident of abuse or neglect of the residents, the SDM will be notified within 12 hours". This was not met as evidenced by the following:

-In an interview during the course of the inspection, the POA for Resident #22 indicated that their loved one was very upset about the incident that happened, when PSW S135

called Resident #22 lazy. Resident #22's POA indicated a PSW informed her of the incident when she was visiting the next day and she was informed later by the RN.

Related to Log #O-000422-14 (Resident #21)

Review of a Critical Incident Report indicated on a specified date and time, Resident #21 was discovered sitting in their room calling for help with a very faint voice. PSW S135 who assisted Resident #21 with a snack did not put back in place the adaptive tool of Resident #21's assistive device for locomotion that allows Resident #21 to control the movement of their assistive device for locomotion as well as a communication system. Resident #21 was left in a state unable to communicate or move their assistive device for locomotion to seek out assistance. Resident #21 was left in that position for over 20 minutes

After Resident #21 was found in this manner, PSW S138 assisted Resident #21 with their adaptive tool used to control his/her assistive device for locomotion. Resident #21 was mad. PSW S138 apologized to Resident #21, Resident #21 indicated that it was not PSW S138's fault that they were left without being able to properly use the adaptive tool.

On a specified date during the course of the inspection, Inspector #570 held an interview with PSW S136 and PSW S137 which indicated that Resident #21 used an adaptive tool to control his/her assistive device for locomotion. If the adaptive tool is moved away to feed Resident #21, it has to be then put back in place so the communication system can work. If the communication system was not in place, we could not hear him/her outside of his/her room.

In review of the home's policy "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 Revised: March 22, 2013). This policy directs staff to complete the following: "Report any witnessed, suspected or alleged abuse to your Supervisor/Manager immediately."

RN S134 who was in charge of home at time of incident was made aware of the incident on the date of occurrence. In an interview held during the course of the inspection, RN S134 indicated that the MOHLTC should have been notified and the manager on call should have been notified. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the date of occurrence. RCM S131 did not see the email until the same day the licensee notified the Director of the incident, 3 days after the alleged incident of abuse. RN S134 failed to comply with policy RCM-RR-590. [s. 20. (1)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that 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: (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.

[Related to Log O-000962-14]

Inspector #550 reviewed a critical incident report that was submitted to the Director by the home. As per the critical incident report, Resident #26 is in a assistive device for locomotion because of a medical condition. On a specified date the resident requested assistance from PSWS127 to pick up an item Resident #26 had dropped on the floor in the dining room at supper time. PSW S127 responded in a loud and rude voice that Resident #26 needs to stop calling staff for assistance when they are busy serving and feeding in the dining room. According to the critical incident report, the CEO came in to the home immediately and began their investigation into the incident involving Resident #26 and PSW S127.

The incident occurred on a specified date and time was not reported to the Director in accordance with legislative requirements. Additionally, during an interview the DRC indicated to Inspector #550 the incident should have been immediately reported to the Director.

Inspector #550 reviewed the home's investigation report related to the allegation of verbal abuse involving Resident #26 and PSW S127. Throughout the report, it was also documented that several staff members and Resident #26 reported to the CEO that PSW S127 had left Resident #26 on the toilet unattended and without the call bell on more than one occasion. The investigation report indicated that PSW S127 was disciplined for these actions.

During an interview, the DRC indicated to Inspector #550 this was an incident of neglect and the DRC could not indicate why it was not reported to the Director. The DRC indicated this incident should have immediately been reported to the Director. [s. 24. (1)]

2. [Related to Log O-000423-14]

Review of Critical Incident Report indicated on the evening of a specified date and time, Resident #22 reported the following: when PSW S135 was assisting Resident #22 with HS (bed time) care PSW S135 called Resident #22 "lazy" and pulled back the bedding on the bed and told Resident #22 that they could do the rest on their own. Interview with PSW S138 indicated on a specified date Resident #22 reported to PSW S138 "that worker made me feel useless" and pointed to PSW S135. PSW S138 told Resident #22 that they were not useless, you are a human being.

Review of Resident #22's clinical documentation and the licensee's investigation into the incident confirm that the alleged staff to resident abuse occurred on a specified date and time.

RN S134 who was in charge of the home at time of incident was made aware of the incident on that specified date. RN S134 indicated that an email was sent to the RCM S131 to notify of incident on the date of occurrence.

Three days after the alleged allegations of abuse had occurred, the licensee notified the MOHLTC of the incident. [s. 24. (1)]

3. [Related to Log O-000422-14]

Review of a Critical Incident Report indicated on a specified date and time, Resident #21 was discovered sitting in their room calling for help with a very faint voice. PSW S135 who assisted Resident #21 with a snack did not put back in place the adaptive tool of Resident #21's assistive device for locomotion that allows Resident #21 to control the movement of their assistive device for locomotion as well as a communication system. Resident #21 was left in a state unable to communicate or move their assistive device for locomotion to seek out assistance. Resident #21 was left in that position for over 20 minutes.

The plan of care in effect at time of incident of on a specified date identified the following:
- for mobility interventions, Resident #21 is independent with assistive device for locomotion moved with an adaptive tool operated by the resident.
- for communication interventions, Resident #21 has a communication system that attaches to the assistive device for locomotion.

During the course of the inspection, Inspector #570 had an interview with the Physiotherapist which indicated that: Resident #21 was independent in mobility and was able to effectively communicate as long as the interventions outlined in the care plan were in place. If not, Resident #21 would be completely dependent on staff.

On a specified date during the course of the inspection, Inspector #570 held an interview with PSW S136 and PSW S137 which indicated that Resident #21 used an adaptive tool to control his/her assistive device for locomotion. If the adaptive tool is moved away to feed Resident #21, it has to be then put back in place so the communication system can work. If the communication system was not in place, we could not hear him/her outside of his/her room.

PSW S138 indicated that on the same specified date, PSW S138 assisted Resident #21 with their adaptive tool used to control his/her assistive device for lcomotion. Resident #21 was mad. PSW S138 apologized to Resident #21, Resident #21 indicated that it was not PSW S138's fault that he/she were left the way that they were.

RN S140 indicated when she spoke to Resident #21 the day after the incident occurred, Resident #21 was upset because PSW S135 left him/her in such a state that left him/her without control and feeling helpless.

Review of Resident #21's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on specified date and time.

RN S134 who was in charge of home at time of incident was made aware of the incident on the same date.

During an interview during the course of the inspection, RN S134 indicated that the MOHLTC should have been notified and the manager on call should have been notified. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the day the incident occurred.

Three days after the alleged allegations of abuse had occurred, the licensee notified the MOHLTC of the incident. [s. 24. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written response is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During an interview with the Residents' Council President, it was indicated that any concerns identified at the meeting are discussed at that meeting and the next meeting but the Residents' Council President was not aware of any written responses.

Review of the Residents' Council Meeting minutes from the last quarter indicated the following concerns and recommendations with no written response provided:
- A concern that visitors do not respect residents when using the elevators. Another concern related to food services that celery is too hard to chew; and a recommendation of having a choice of minced salad.
- Concerns were brought forth regarding: Lack of aprons for the residents at meal service; Residents are taking their walkers in the dining room; Lifts and slings that are being used not working properly and staff need training in this area. In a specific Resident care area dining room at meal times a resident strips down to his underwear. A recommendation by one resident to have a spiritual group to discuss and prepare for the afterlife;
- Concerns were brought forth regarding: Frequency of physician's visits; Lifts not functioning on one home area; Lack of aprons for residents during meals; Staffing concerns in one home area; a resident was concerned about the length of time he waits after ringing the call bell; a resident concerned about missing personal belongings; concerns about the food and kitchen processes.

During an interview with the CEO, it was indicated that a response is not provided in writing within 10 days to concerns but concerns are addressed verbally during the Residents' Council meetings. [s. 57. (2)]

WN #10: 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. The licensee has failed to ensure that all staff have receive retraining annually relating to the following:

* The Residents' Bill of Rights
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty to make mandatory reports under section 24
* The whistle-blowing protections.

Inspector #550 reviewed the home's training record for 2013 for the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections and observed the following:
281/308 employees received training on the Residents' Bill of Rights
279/308 employees received training on the home's policy to promote zero tolerance of abuse and neglect of resident
281/308 employees received the training on the duty to make mandatory reports under section 24
281/308 employees received the training on the whistle-blowing protections

During an interview the DRC indicated to Inspector #550 she was aware that training was going to be an issue as not all staff had completed the training requirements for the year 2013. [s. 76. (4)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

In an interview with the Residents' Council President it was indicated to Inspector #570, that the Residents' Council President was unaware of the home seeking the advice of the Residents' Council in developing and carrying out the Residents' satisfaction survey.

During an interview with the CEO indicated that the Residents' Council was not consulted with respect to the development of the satisfaction survey for the year 2014. [s. 85. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by
those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #550 reviewed the home's zero tolerance of abuse and neglect, policy #RCM-RR-590, with a revision date of March 22, 2013. The policy does not contain any provision for procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, identifying measures and strategies to prevent abuse and neglect, identifying the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

During an interview the DRC indicated to Inspector #550 the home's written policy on zero tolerance of abuse and neglect does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, identifying measures and strategies to prevent abuse and neglect, identifying the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations and that the home will be adding these issues to their policy.

Before the end of the inspection process, the DRC provided Inspector #553 a revised copy of policy #RCM-RR-590, which included all of the above mentioned areas that were previously not included. [s. 96. (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. [Related to Log O-000423-14]

The licensee has failed to ensure that a resident's SDM was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Review of Resident #22's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on a specific date and time.

During the course of the inspection, an interview was held with the POA for Resident #22, who indicated that Resident #22 was very upset about the incident that happened when PSW S135 called Resident #22 "lazy". Resident #22's POA indicated a PSW informed her of the incident when she was visiting the next day and she was informed later by the RN.

RN S134 documented in a progress note three days after the incident had occurred that POA for Resident #22 was updated of the events that took place which had upset the resident. The POA stated her father had told her about incident on the subsequent day. Writer assured daughter that it was being taken very seriously and appropriate follow up was under way. [s. 97. (1) (b)]

WN #14: 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) The licensee shall ensure that 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 the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #9 had a significant change in health condition which required a transfer to hospital.

A review of the health care records for Resident #9 indicated that on a specified date, during the night PSW found Resident #9 sitting on the floor in the resident's bathroom. The registered staff completed a physical assessment which indicated that Resident #9 sustained an injury. Resident #9 was transferred to the hospital for further diagnostic imaging and clinical assessments.

The resident's health care records also indicated the following;

On a specified date and time RPN S123 contacted PRHC (Peterborough Regional Health Centre) and was informed that Resident #9 was awaiting surgery.

3 days after the aforementioned specified date Resident #9's POA informed the home that Resident #9 had under gone surgery.

Resident #9 sustained an injury on a specified date and time which resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital. The DRC stated to Inspector #549 that she became aware of Resident #9's injury and transfer to hospital 3 days after the initial injury occurred.

The Director was notified of the significant change in the resident's health condition for which the resident was taken to hospital 10 days after the initial injury occurred, which is more than one business day after the DRC became aware of the injury to Resident #9.

During the course of the inspection, the DRC confirmed with Inspector #549 that the Director was not informed no later than one business day after the occurrence of an injury to Resident #9 that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital. [s. 107. (3)]

Issued on this 6th day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MATTHEW STICCA (553), JOANNE HENRIE (550), MEGAN MACPHAIL (551), RENA BOWEN (549), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2014_292553_0035
Log No. / Registre no:	O-001139-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 12, 2014; Jan 5, 2015
Licensee / Titulaire de permis :	CITY AND COUNTY OF PETERBOROUGH 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
LTC Home / Foyer de SLD :	FAIRHAVEN 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOY L. HUSAK

To CITY AND COUNTY OF PETERBOROUGH, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007 s. 19 (1) to ensure all residents are protected from abuse and or neglect.

This plan shall include :

-a revised Zero Tolerance of Abuse and Neglect policy to contain any provision for procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate, identifying measures and strategies to prevent abuse and neglect, identifying the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

- a mandatory, comprehensive and interactive education session for all direct care staff offered in various formats to meet the learning needs of adult learners on all forms of abuse and or neglect, mandatory reporting, and the revised Zero Tolerance of Abuse and Neglect policy. As well as defined interventions to support staff in the integration of this education into their day to day practice,

-a system to monitor and evaluate staff adherence to the Zero Tolerance of Abuse and Neglect Policy.

-a system to monitor and ensure that all staff complete the Licensee's retraining

requirements on an annual basis in areas as specified under s.76 (2) of the LTCHA, 2007. Related to WN #10.

-The development and implementation of a monitoring process to ensure that:
- the resident's SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse and are notified with 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
- the Director is immediately notified if there are reasonable grounds to suspect the 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.

-the plan should also identify who is responsible for ensuring the completion of each and every item listed above.

The plan shall identify the time line for completing the tasks
The plan is to be submitted to Matt Sticca by January 7, 2015 via email to Matthew.Sticca@ontario.ca.

Grounds / Motifs :

1. The licensee failed to comply with LTCHA 2007 s.19 by failing to protect Residents #26, #21 and #22 from abuse and or neglect.

Definitions:
Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,"emotional abuse" means, (a)any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg 79/10 s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a)any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Under O. Reg. 79/10, s. 5 For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care,

services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Resident #26:
Resident #26 requires the use of an assistive device for locomotion. On a specified date and time while in the dining room during dinner service, Resident #26 requested assistance from PSW S127 to pick up an item Resident #26 had dropped on the floor. PSW S127, who works full time in the home, responded in a loud and rude voice that Resident #26 needs to stop calling staff for assistance when they are busy serving and feeding in the dining room. This was overheard by a registered staff member who was also in the dining room at the time.

Upon becoming aware of this occurrence the CEO came into the home on a specified date and began their investigation into this incident of verbal abuse. In review of the home's investigation, Resident #26 disclosed to the CEO that on "numerous occasions" Resident #26 had been left on the toilet by PSW S127 without giving Resident #26 the call bell. Three additional staff members confirmed this allegation to the CEO. PSW S127 was disciplined for these actions.

The incident that occurred on a specified date and time was not reported to the Director in accordance with legislative requirements. Additionally the incident(s) of Resident #26 being left on the toilet by PSW S127 without giving the call bell to Resident #26 was never reported to the Director. This was confirmed by the DRC who stated that they could not provide a reason as to why the incident on a specified date was not reported immediately or a reason as to why the home never notified the Director of the incident of neglect.

The licensee failed to comply with:
-LTCHA, 2007 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. (WN #7)
-LTCHA, 2007 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: 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. (WN #8)

Related to Resident #22:
On a specified date and time, Resident #22 reported the following: when PSW S135 was assisting Resident #22 with HS (bedtime) care PSW S135 called Resident #22 "lazy" and pulled back the bedding on the bed and told Resident #22 that they could get into bed on their own.
Interview with PSW S138 indicated on the same specified date, Resident #22 reported to PSW S138 "that worker made me feel useless" and pointed to PSW S135. PSW S138 told Resident #22 that they were not useless, you are a human being.
Interview with RN S134 indicated that on the same specified date, RN S134 was notified of the incident and spoke to Resident #22. Resident #22 was very teary and was hurt by PSW S135's actions.
Resident #22's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on the same specified date. RN S134 who was in charge of the home at time of incident was made aware of the incident later on the same specified date. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the specified date that the incident occurred.
In a review of the home's policy, "Zero Tolerance of Abuse and Neglect" (# RCM-RR-590 revised: March 22, 2013), indicated that staff are to: "report any witnessed, suspected or alleged abuse to your Supervisor/Manager immediately". This action was not met by RN S134 who sent an email to RCM S131. RCM S131 read the email on three days after the incident had occured, which was the same day the licensee notified the MOHLTC of the incident.

During the course of the inspection, the POA for Resident #22 indicated that their loved one was very upset about the incident that happened on the evening of the specified date when PSW S135 called Resident #22 lazy. Resident #22's POA indicated a PSW informed her of the incident when she was visiting the next day and she was informed later by the RN.

The licensee failed to comply with:
-LTCHA, 2007 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. (WN #7)
-LTCHA, 2007 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: 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. (WN #8)
-O.Reg 79/10 s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision maker,if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. (WN #13)

Related to Resident #21:
On the same specified date as the occurrence involving Resident #22, Resident #21 was discovered sitting in their room calling for help with a very faint voice. PSW S135 who assisted Resident #21 with a snack did not put back in place the required adaptive tool of Resident #21's assistive device for locomotion that holds the adaptive tool and a communication device required for Resident #21. Resident #21 was left in such a state that they were unable to communicate or move their assistive device for locomotion to seek out assistance. Resident #21 was left in that position for over 20 minutes.

The plan of care in effect at time of incident of on a specified date identified the following:
- for mobility interventions, Resident #21 is independent with assistive device for locomotion moved with an adaptive tool operated by the resident.
- for communication interventions, Resident #21 has a communication system that attaches to the assistive device for locomotion.

PSW S138 indicated that on the same specified date, PSW S138 assisted Resident #21 with their adaptive tool used to control his/her assistive device for locomotion. Resident #21 was mad. PSW S138 apologized to Resident #21, Resident #21 indicated that it was not PSW S138's fault that he/she were left the way that they were.
RN S140 indicated when she spoke to Resident #21 the day after the incident occured, Resident #21 was upset because PSW S135 left him in such a state that left him/her without control and feeling helpless.

Review of Resident #21's clinical documentation and the licensee's investigation into the incident indicate the alleged staff to resident abuse occurred on a specified date and time. RN S134 who was in charge of home at time of incident was made aware of the incident on the same specified date. During an interview

during the course of the inspection, RN S134 indicated that the MOHLTC should have been notified and the manager on call should have been notified. RN S134 indicated an email was sent to the RCM S131 to notify of incident on the date of the occurrence. Three days after the incident the licensee notified the MOHLTC of the incident.
It should be noted that on a specified date PSW S135 was involved in two incidences of abuse and or neglect involving two different residents, (Resident #21 and Resident #22). Inspector #570 and #553 reviewed the PSW staffing schedule for the time period around the incidences of abuse; during that time frame PSW S135 continued to work in the home. One day after the alleged incidents occurred, PSW S135 was working in the home for 7.33 hours, and two days after the alleged incidents occurred PSW S135 was working in the home for 7.90 hours. Three days after the alleged occurrences of abuse and or neglect RCM S131 was made aware of the transgressions of PSW S135 via an email sent by RN S134; PSW S135 was suspended pending investigation into the alleged allegations.

In an interview during the course of the inspection the DRC stated to Inspector #553 that indeed PSW S135 worked in the home for the two days after being involved in two separate incidences of abuse and or neglect of a resident. However, PSW S135 was not working in the same resident care area as they were on the specified date when PSW S135 was involved in the two incidences with Resident #21 and #22. PSW S135 no longer is employed by the home.

The licensee failed to comply with:
-LTCHA, 2007 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 (WN #7)
-LTCHA, 2007 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: 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. (WN #8)
-LTCHA, 2007 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. (WN #6)

In addition to the individual incidents and the areas of non-compliance identified for the incidents involving Residents #26, #22 and #21, the following was also

identified.
-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 (as identified in WN #10)

-The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and
the potential for abuse and neglect by those in a position of trust, power and responsibility
for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg.79/10, s. 96. (as identified in WN #12)
(553)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Matthew Sticca

Service Area Office /
Bureau régional de services : Ottawa Service Area Office