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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 8, 2013	2013_196157_0007	001188, 001695, 002317	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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 19, 20, 21, 22, 2013

During the course of this inspection, three Critical Incidents were inspected: Log#001188-12, Log#001695-12, Log#002317-12.

During the course of the inspection, the inspector(s) spoke with the Administrator,the Director of Resident Care(DRC), two Resident Care Manager (RCM), two Registered Practical Nurses (RPN), four Personal Support Workers (PSW), residents.

During the course of the inspection, the inspector(s) reviewed the home's compliance history, clinical health records of four identified residents, facility reports related to three critical incidents, observed care and services provided to residents, reviewed the home's education records related to resident abuse prevention, reviewed facility policies and procedures related to Resident Abuse and Neglect, Missing Residents, Security Cameras, Building Security, Wanderguard System, Resident Safety Re:Wandering Behaviour, Resident Behaviour Tracking and Falls Prevention.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A Critical Incident report indicates that on three occasions an identified resident was verbally and physically aggressive towards another resident, resulting in physical injury to the resident.There is no evidence that interventions were put in place to protect the resident from abuse. (Log #001188-12) [s. 3. (1) 2.]

2. As defined in the Long Term Care Homes Act, 2007, O.Reg. 79/10, s.2.(1), emotional abuse is "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement, infantilization that are performed by anyone other than a resident."
A Critical Incident reports indicates that an identified resident was not protected from emotional abuse as a result of the actions of staff members whose actions constituted insulting, humiliating behaviour directed towards the resident. (Log #002317) [s. 3. (1) 2.]

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 every resident's right to be protected from abuse is fully respected and promoted., 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The home's policy "Abuse of Residents", Policy Number ADM-ORG, Approved January 8, 1997, Revised January 12, 2013, fails to comply with all applicable requirements under the legislation:

O.Reg. 79/10, s.96.(e)(i) requires that the home's policy to promote zero tolerance of abuse and neglect of residents, identify the training and retraining requirements for all staff and include 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. The home's policy does not address this issue.

O.Reg. 79/10, s.219(1) requires that retraining on the long term care home's policy to promote zero tolerance of abuse and neglect of residents be conducted annually. The home's policy does not provide this direction. The policy states that "periodic in service sessions will be held" for employee training.

O.Reg. 79/10, s. 97(1) requires that the resident's substitute decision maker be notified:
(a) immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect that has resulted in physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's well-being; and
(b) with 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident.
The home's policy does not provide this direction. The policy states that "Where in the judgement of the Executive Director, an allegation of abuse is not founded, she may nevertheless consider it appropriate to inform the family of the situation." [s. 20. (2)]

WN #3: 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. A Critical Incident report indicates that the Substitute Decision Maker (SDM) for an identified resident was not notified of an alleged incident of staff to resident abuse. (Log #002317-12) [s. 97. (1) (b)]

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. An identified resident was physically aggressive with another resident on three occasions, resulting in physical injury to the resident. There is no evidence that police were immediately notified of these witnessed incidents of abuse. (Log #001188-12) [s. 98.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The Director of Resident Care confirmed that the home Abuse Evaluation Program is in a draft form and has not been implemented. Therefore an evaluation has not been made at least once in every calendar year to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.(Log #002317-12, 001188-12) [s. 99. (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. An alleged incident of staff to resident abuse was reported and confirmed to have occurred. The licensee failed to submit the CI report with 10 days of becoming aware of the alleged incident.(Log #002317-12) [s. 104. (2)]

Issued on this 8th day of March, 2013

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