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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Mar 3, 2017	2017_552531_0007	004319-17, 004370-17	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the 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

SUSAN DONNAN (531)

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 27, 2017.

Log #004370-17 related to alleged resident to resident abuse.
Log #004319-17 related to alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, residents' substitute decision makers (SDM), Personal Support Workers PSWs, Registered Practical Nurses (RPN), a Registered Nurse (RN), the Resident Care Manager (RCM), the Director of Care and the Administrator.
In addition, the inspector observed resident care and services, reviewed resident health records including the licensee`s investigation notes; consult notes; and abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director;
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

Related to log #004370-17 alleged resident to resident abuse.
Critical Incident System (CIS) Report submitted to the Director indicated that on a specified date a PSW staff member observed resident #001 seated beside resident #002 inappropriately touching the co-resident. Resident #002 was removed from the area and the PSW reported the incident to the nurse in charge.

Resident #001's diagnoses include the resident as cognitively sound and responsible for own care decisions.

Resident #002's diagnoses include cognitive impairment secondary to dementia .

On a specified date PSW #104 and PSW #106 were interviewed and both indicated they witnessed resident #001 inappropriately touching resident #002. PSW #104 told inspector #531 that she observed resident #001 seated on a hall bench next to resident #002 . She indicated that resident # 001 had barrier cream in hand and explained that he/she was going to apply the cream to resident #002's dry hands. PSW #104 indicated she returned in less than two minutes with PSW #106 and noted resident #001 inappropriately touching resident #002. PSW #106 indicated that she removed resident #002 from the area. PSW #104 and #106 indicated that resident #002 did not comprehend resident #001's inappropriate touching and resident #002 did not exhibit signs of distress. Both indicated that PSW #104 reported the incident to the RPN in charge.

RPN #105 indicated that she reported the incident to the RN in charge, both PSWs and RPN #105 completed "investigative statements" and submitted the statements to the Resident Care Manager for immediate investigation. RPN #105 indicated that resident #001's care plan was revised, a DOS (Dementia Observation Scale) was initiated including monitoring and documentation.

RPN #108 was interviewed and indicated that during breakfast on a specified date, resident #001 was noted rubbing resident #002's leg . She indicate that resident #001's care plan was revised to include 1:1 monitoring.

On February 27, 2017 during an interview the Resident Care Manager (RCM) indicated she immediately initiated an investigation, notified the residents' SDMs however the Ministry of Health and Long Term Care Director was not notified immediately. [s.24. (1)]

WN #2: 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. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee
suspects may constitute a criminal offense.

Related to log # 004370-17.

On a specified date a Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care reporting an alleged resident to resident abuse.

During an interview with the Resident Care Manager (RCM) and review of the Critical Incident she indicated that she completed the "long term care police reporting form" however did not forward the form to notify the police until the next afternoon. [s. 98.]

Issued on this 22nd day of March, 2017

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

Original report signed by the inspector.