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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 2, 2017	2017_598570_0025	022113-17	Resident Quality Inspection

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

SAMI JAROUR (570), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 19, 20, 23, 24, 25, 26, 27, 30 and 31, 2017.

The following Critical Incidents Reports (CIR) Logs were included in this inspection:

Logs #033891-16, 002434-17, 002568-17, 008655-17 and 019489-17 related to resident's fall that resulted in an injury.

Logs #010033-17, 013996-17, 019781-17, 021524-17, 023237-17, 023636-17 and 015373-17 related to allegations of resident to resident abuse.

Logs #028867-16, 013900-17, 014181-17, 014189-17, 015684-17, 018816-17, 022636-17, 023816-17 and 023817-17 related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Chief Executive Officer (CEO), the Director of Care (DOC), Resident Care Managers (RCM), Resident Care Supervisor (RCS), Environmental Services Manager (ESM), Environmental Services Supervisor (ESS), Programs Manager, Physiotherapist (PT), Activation Aide, Dietary Aide, Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support staff (BSO), Resident and Family Council representatives.

During the course of the inspection, the inspector(s) toured the home, observed staff to resident interactions, resident to resident interactions, infection control practices and medication administration; reviewed clinical records and the licensee's Zero Tolerance of Abuse and Neglect Policy.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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. The licensee has failed to ensure that the care set out in the plan of care for resident #011 related to a specific intervention for responsive behaviour was provided to the resident as specified in the plan.

Related to Log #013996-17:

Critical Incidence Report (CIR) was submitted on an identified date for an incident of resident to resident sexual abuse involving resident #011.

Resident #011 was admitted to the home on an identified date. A specified intervention was initiated for resident #011 on an identified date, related to responsive behaviours exhibited by the resident. On an identified date, three days later, PSW #128 was providing the identified intervention for resident #011.

During an interview with Inspector #194 on October 25, 2017, PSW #128 indicated going for break at an identified time, resident #011 was sleeping, door alarm was initiated and PSW's on the unit were informed that the staff was leaving the unit. While PSW #128 was on break, resident #011 wandered out of the bedroom looking for the resident's spouse and ended up in a co resident's bed.

The plan of care for resident #011 in effect at the time was reviewed by Inspector #194. The plan of care directed that resident #011 was to be provided a specified intervention for responsive behaviours during days, evening and nights

Separate interviews with RCM #129 and BSO #134 were conducted by Inspector #194 on October 25, 2017. Both RCM #129 and BSO #134 indicated that Personal Support Workers providing the specified intervention for responsive behaviours were to report to the RPN on the units prior to leaving for breaks and that residents being provided the intervention were not to be left unattended. During same interview with Inspector #194, RCM #129 indicated that PSW #128 did not inform RPN #127 that he/she was leaving the floor and going for break on an identified date.

On an identified date, the care set out in the plan of care for resident #011 for identified intervention was not provided as specified, resulting in a responsive behaviour. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to residents as specified in the plan specific to an intervention of responsive behaviours, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the Abuse policy "zero tolerance of abuse and neglect" RCM-RR-590 dated September 15, 2016 was completed by Inspector #194 on October 24, 2017

Page 2 of 7 Roles of all employees of Fairhaven

It is mandatory that all staff of Fairhaven report any act, report of act, or allegation of resident abuse to a member of the registered staff or management team as soon as incident occurs.

Related to Log # 014189-17:

On an identified date, a Critical Incident Report (CIR) was submitted for an incident of alleged staff to resident abuse. The CIR describes that resident #031 was being assisted to bed by PSW #116. PSW #117 was standing outside the bedroom door and overheard

resident #031 state "you didn't have to throw the blankets on my face".

During a telephone interview, PSW #117 indicated to Inspector #194 that the incident of verbal abuse was not reported immediately because of repercussions towards staff by PSW #116.

PSW #117 did not comply with the home's abuse policy "zero tolerance of abuse and neglect" RCM-RR-590 when the incident of verbal abuse was not reported as required. [s. 20. (1)]

2. Related to Log # 013900-17:

On an identified date, a Critical Incident Report (CIR) was submitted for an incident of alleged staff to resident verbal abuse. The CIR describes that resident #026 was being provided continence care by PSW #116 and PSW #118. PSW #118 witnessed PSW #116 yelling at resident #026 saying "why didn't you ring to be changed before we got here".

During an interview, on October 24, 2017, PSW #118 indicated to Inspector #194 that the incident of verbal abuse involving resident #026 was not reported immediately because of repercussions towards staff by PSW #116.

PSW #118 indicated to Inspector #194 during the same interview that abuse education had been provided and that PSW #118 was aware of the reporting requirement related to abuse.

PSW #118 did not comply with the home's abuse policy "zero tolerance of abuse and neglect" RCM-RR-590 when the incident of abuse was not reported as required. [s. 20. (1)]

3. Related to Log #018816-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time, related to an alleged incident of staff to resident verbal abuse, which occurred on an identified date, between RPN #120, and resident #027. According to the CIR, on an identified date, RPN #120 entered the bedroom of resident #027, and found the resident removing a soiled incontinent product, and also noted dark brown staining on the resident’s nightgown, therefore informed the resident that they required assistance with

personal care, and rang the call bell for PSW assistance. Resident #027 had refused staff assistance; PSW #121 then responded to the call bell, and reported that RPN #120 stated to the resident "things are going to change and you need to start taking care from staff", and RPN #120 "forced" PSW #121 to assist resident #027 with care.

During an interview on October 24, 2017, resident #027 indicated that they recalled the incident which had occurred on an identified date, between them and RPN #120. Resident #027 further indicated that RPN #120 had been verbally abusive during the incident, that RPN #120 had forced a PSW staff member to assist with personal hygiene care, although resident #027 did not wish to receive assistance from a staff member, and the incident had made them feel humiliated.

Inspector #672 reviewed the internal investigational notes into the incident, which revealed that resident #027 reported the incident to PSW staff on the following morning. The PSW staff reported the allegation to the Registered Staff on duty, who then reported the allegation to Resident Care Manager (RCM) #114. RCM #114 initiated the internal investigation, which was completed two days later. The internal investigational notes included a written statement from PSW #121, who indicated that on an identified date and time, RPN #120 had "forced" the PSW to complete care on resident #027, and that RPN #120 had made a statement to resident #027, that "things are going to change, you need to start taking care from staff".

During an interview on October 24, 2017, RCM #114 indicated that the incident was first reported to staff by resident #027, on the following morning, which led to the internal investigation being initiated. RCM #114 further indicated that PSW #121 had received staff education regarding prevention of resident abuse and neglect, along with the required reporting guidelines related to allegations of resident abuse and neglect. RCM #114 further indicated that the expectation of all staff members was that if an incident of resident abuse or neglect was observed or reported, staff were to immediately report the incident to the Registered Staff on duty, who would in turn immediately inform the management staff.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, when PSW #121 failed to report an alleged incident of staff to resident verbal abuse, which occurred between RPN #120, and resident #027, on an identified date. [s. 20. (1)]

4. Related to Log #023817-17:

A Critical Incident Report (CIR), was received on an identified date reporting an alleged incident of staff to resident verbal abuse which occurred on an identified date four days earlier involving resident #040.

On an identified date, the Environmental Service Supervisor (ESS) was contacted by resident #040 to report that housekeeping staff #141 had been verbally abusive. Resident #040 reported to the ESS that on an identified date, while in the resident's room, housekeeper #141 stated to the resident "that the resident had too much stuff and that the resident was filthy". Resident #040 indicated to the ESS that they were very insulted by this comment.

During an interview with Inspector #194 on October 30, 2017, the DOC confirmed that the ESS did not report the allegation of verbal abuse to the Resident Care Manager (RCM) as per policy.

The Environmental Service Supervisor did not comply with the home's abuse policy "zero tolerance of abuse and neglect" RCMRR-590 when the incident of verbal abuse was not reported as required. (194) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with specific to reporting of allegations of abuse of residents, to be implemented voluntarily.

WN #3: 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 a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to Log #018816-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and time, related to an alleged incident of staff to resident verbal abuse, which occurred two days prior, between RPN #120, and resident #027. According to the CIR, on an identified date and time, RPN #120 entered the bedroom of resident #027, and found the resident removing a soiled incontinent product, and also noted dark brown staining on the resident's nightgown, therefore informed the resident that the resident required assistance with personal care, and rang the call bell for PSW assistance. Resident #027 had refused staff assistance; PSW #121 then responded to the call bell, and reported that RPN #120 stated to the resident "things are going to change and you need to start taking care from staff", and RPN #120 "forced" PSW #121 to assist resident #027 with care.

Inspector #672 reviewed the internal investigational notes on an identified date, related to the incident between resident #027 and RPN #120. The internal investigational notes revealed the resident #027 had reported the incident to a PSW staff member the

morning, who in turn immediately reported the incident to the Registered Staff on duty, who then informed RCM #114. RCM #114 then initiated the internal investigation.

During an interview on October 24, 2017, RCM #114 indicated that he/she had initially been notified of the alleged incident between resident #027 and RPN #120 on the following morning. RCM #114 further indicated that the incident had not been called in to the Ministry of Health and Long Term Care on the date when he/she was notified of the incident, and that the Critical Incident Report was not submitted to the Director until the following day.

The licensee failed to ensure that the Director was immediately notified of an allegation of staff to resident verbal abuse, which occurred between resident #027 and RPN #120, on an identified date and time. [s. 24. (1)]

2. Related to log 021524-17:

On an identified date, a Critical Incident Report (CIR) was submitted to the Director reporting an alleged incident of resident to resident sexual abuse, which occurred on an identified date two days prior.

Review of the CIR documentation indicated a Personal Support Worker (PSW) while completing rounds at an identified date and time, the PSW found resident #038 on the floor in own room not wearing a night gown.

Resident #038, who was cognitively impaired was assessed, no injury was noted. Resident #038 was asked by staff what happened and indicated they did not know. Resident #038, after being asked several times, eventually said resident #037 took me out.

Review of the licensee's investigation, clinical documentation and interview with the Director of Care indicated no evidence that resident #037 pulled resident #038 from bed and removed the night clothes. The licensee's investigation indicated resident #038, removed the night clothes to which the bed alarm was attached and climbed out of bed. Resident #037, who is cognitively impaired was wandering in the hall at the same time resident #038 was found on the floor in bedroom.

The Director was notified of the allegations of resident to resident abuse on an identified date, two days post incident. [s. 24. (1)]

3. Related to log 015684-17:

On an identified date, a Critical incident Report (CIR) was submitted to the Director, reporting an alleged incident of staff to resident verbal abuse, which occurred on an identified date three days prior.

Review of the CIR indicated on the date of the incident, Personal Support Worker (PSW) #139 answered a resident call bell and allegedly spoke to resident #039, indicating to the resident, because of the constant ringing of the call bell, the PSW was behind in their work and later PSW #139 allegedly made a rude finger gesture directed towards resident #039.

Review of the licensee's investigation, witness statements and interview with the Director of Care indicated, the incident of alleged verbal abuse was reported to the Resident Care Manager (RCM) on the same date of the incident.

The Director was not notified of the alleged staff to resident verbal abuse until three days post incident. [s. 24. (1)]

4. Related to Log #022636-17:

On an identified date, a Critical Incident Report (CIR) was received reporting an alleged incident of staff to resident verbal abuse which occurred on an identified date seven days prior.

Review of the CIR documentation indicated a report of an allegation of staff to resident verbal abuse was submitted to the Resident Care Manager on an identified date one day before submitting the CIR. The report indicated PSW #140, was witnessed yelling at resident #042, "you spilled your drink" and then forcefully shove the resident, who was in a wheelchair, out of the way to clean the spill.

The licensee became aware of the allegations of staff to resident verbal abuse on an identified date. The Director was not notified immediately of the allegations of staff to resident verbal abuse. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that any suspicion of abuse of a resident by anyone is immediately reported to the Director, to be implemented voluntarily.

WN #4: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

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. The licensee has failed to ensure that the report to the Director included the name of the staff member who was involved in an alleged incident of staff to resident verbal abuse, the name of the staff member who was present during the alleged incident, and the name of the staff member who the resident reported the alleged incident to.

Related to Log #018816-17:

A Critical Incident Report (CIR) was submitted to the Director on an identified date and

time, related to an alleged incident of staff to resident verbal abuse, which occurred on on an identified date, between RPN #120, and resident #027.

Inspector #672 then reviewed the Critical Incident Report, which was submitted to the Director on an identified date, revealed that under the "Staff who were present" section of the CIR, there were no names listed. The name of the PSW to whom resident #027 initially reported the incident to on the following morning, was also not included within the Critical Incident Report.

During an interview on October 24, 2017, RCM #114 indicated to Inspector #672 that all names of the staff members involved in the incident should have been included in the report submitted to the Director.

The licensee failed to ensure that the report to the Director included the name of the RPN who had been involved in the alleged incident, the name of the PSW staff member who was present during the alleged incident, along with the name of the PSW who resident #027 initially reported the alleged incident to on the morning of the next day. [s. 104. (1) 2.]

2. The licensee has failed to ensure that a written report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident of resident to resident sexual abuse, which occurred on an identified date.

Related to Log #015373-17:

On an identified date, an after hours report was received reporting an alleged incident of resident to resident sexual abuse that occurred on the same date when resident #043 came into the dining room and grabbed resident #044's body part.

On October 30, 2017, interview with the Director of Care, indicated, he/she was not able to locate a written Critical Incident Report related to the allegations of resident to resident sexual abuse which occurred on an identified date.

The DOC indicated, although the alleged incident of resident to resident sexual abuse was reported using the after hours reporting process, a written report should have been made and forwarded to the Director within 10 days of becoming aware of the incident. [s. 104. (2)]

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

Specifically failed to comply with the following:

s. 107. (3) 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 was informed no later than one business day after the occurrence of 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 was taken to a hospital.

Related to Log #002434-17:

A Critical Incident Report was received on an identified date for resident #029 who was transferred to hospital due to a fall. The CIR indicated, the resident was diagnosed with an injury.

Review of progress notes for resident #029 indicated, on an identified date, the resident was found on the floor and complained of pain in an identified body part. The resident was transferred to hospital and returned on same day with a confirmed diagnosis of an injury and an order of bed rest.

On October 25, 2017, during an interview, the Resident Care Manager (RCM) #129 indicated the CIR was submitted due to the resident's diagnosis of the identified injury resulting in a significant change in resident's status. The resident was on bed rest and required the use of a specified mobility and positioning device. RCM #129 further indicated that the CIR was not reported within one business day of becoming aware of the resident's diagnoses and change of status.

The Director was not notified of the incident involving resident #029 until after three business days of the confirmed diagnosis of identified injury resulting in significant change in the resident's health condition. [s. 107. (3)]

Issued on this 8th day of November, 2017

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

Original report signed by the inspector.