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

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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 27, 2018	2018_603194_0005	026113-17	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
c/o Fairhaven 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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 29, 30, February 1, 2 and March 1 and 2, 2018

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physio Therapist (PT), Physio Therapy assistant (PTA), Registered Dietitian (RD) and Programs and Volunteer Manager

The inspector reviewed clinical health record of identified residents, complaint log, complaint policy and the identified resident's clinical health records.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to resident #006's responsive behaviours.

Fairhaven received a written complaint on an identified date, related to concerns about resident #006's care. The complaint letter along with the home's response was forwarded to the Ministry of Health and Long Term Care.

Resident #006 was admitted with cognitive impairments and ambulated independently without a walker.

Review of resident #006's progress notes for the period of two months related to responsive behaviours were completed.

The progress notes identified that there were 18 separate entries identifying that resident #006 was exhibiting an identified responsive behaviour

Interviews conducted by inspector #194 with RN #114, RPN #115 and RCC #109, all indicated that the behaviour for resident #006 had been identified and that staff were to redirect resident.

Review of the plan of care for resident #006 for the identified period did not provide strategies for the responsive behaviour.

The progress notes identified that for the period of two months, there were seven separate incidents of resident #006 exhibiting another responsive behaviour.

Interviews conducted by inspector #194 with RN #114, RPN #115, RPN #126 and PSW #123 related to resident #006's responsive behaviour, indicated that the behaviour had been identified and that staff were to redirect the resident.

Review of the plan of care did not provide any strategies developed to respond to the resident's responsive behaviour until the following month.

Resident #006 was provided strategies to manage both responsive behaviours, one month after the review period. [s. 53. (4) (b)]

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Issued on this 28th day of March, 2018

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

Original report signed by the inspector.