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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2018	2018_643111_0020	002375-18, 004739-18, 005587-18	Critical Incident System

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

LYNDA BROWN (111)

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): September 12 to 14, 17 to 20, 2018

The following four critical incident inspections were completed concurrently:
-Log # 004739-18 (CIR), 002375-18 (CIR), 005587-18 (CIR) and 003994-18 (CIR) related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Managers (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), Nutritional Service Manager (NSM) and residents.

During the course of the inspection, the inspector reviewed resident health records, reviewed the licensee's investigations and reviewed the Zero Tolerance of Abuse and Neglect policy.

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.
- **4 WN(s)**
- **4 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	Légende 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. 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 :

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

Related to Log # 004739-18:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, the SDM of resident #021 reported to the Social Worker (SW) that PSW#125 had been emotionally abusive to the resident and made the resident "very uncomfortable".

Review of the licensee's policy "Zero Tolerance of Abuse and Neglect" (RCM-RR-590) revised November 2017 indicated:
- On page 3 of 7: complete a detailed description using the Incident Investigation Form including where the incident happened, who was involved, when it happened, what occurred and what interventions were put in place. Ensure that the resident is not left in the responsibility of the person alleged to have caused the abuse or neglect.
-On page 5 of 7, the Registered Staff/Management Team will notify Senior Management. The Registered Staff/Management Team will notify all parties involved and begin investigation by having persons involved complete in detail, the incident investigation form immediately while those who have knowledge of the incident are still on duty or in the building.
-On page 6 of 7, the Registered Staff/Management Team will inform the employee that he/she is suspended pending further investigation, if appropriate.

Review of the licensee's investigation into the alleged staff to resident emotional abuse indicated:
- the SW completed the Incident Investigation Form, a number of days after the allegation was made and pages were left incomplete. The SW indicated the allegation was reported to both RCMs, RPN #147 and RN #148.
- RCM #108 also completed a Incident Investigation Form, a number of days after the allegation was made and several areas were also left incomplete. The RCM interviewed the resident, a number of days after the allegation was made. The RCM relieved PSW #125 of duty, the day after the allegation was made. The RCM indicated the resident reported the incident had occurred approximately a week prior.
-PSW #125 was interviewed a number of days after the allegation was received, by the DOC. The PSW confirmed they had received notification during shift report that resident #021 stated the resident had received improper care by the specified shift and the PSW questioned the resident regarding the allegation and the resident denied the allegation.

The DOC did not determine when the incident actually occurred. The investigation was concluded the same day and determined to be unfounded.

Review of the progress notes for resident #021 indicated on a specified date and time, the resident was heard expressing improper care to co-residents during a meal time. The following day, at a specified time, the SW met with the resident to discuss the 'ongoing' comments being made to co-residents during mealtimes by resident #021, when the SDM reported the alleged staff to resident abuse by PSW #125 towards the resident.

Review of the staffing schedule indicated: on the day the alleged staff to resident abuse occurred, PSW #125 had worked and provided care to residents on the same unit as resident #021, after the incident occurred and was not removed from providing resident care,until the day after the allegation was made. The staffing schedule also indicated RCMs (#108 and #128) were both working at the time the allegation was made.

Interview with RPN #124 by Inspector #111, indicated on a specified date (a number of days before the allegation was reported), resident #021 reporting improper care provided by a specified shift, on a specified date and time. The RPN indicated this information was documented in the resident's progress notes and then reported to the oncoming shift staff.

Interview with PSW #125 by Inspector #11, indicated on a specified date (a number of days before the allegation was reported), the PSW had received report at the beginning of the shift, that resident #021 had reported that a specified shift provided improper care, so the PSW on that specified shift, asked the resident regarding the comments made. The PSW indicated they did not think that they were confronting the resident, but just asking the resident why they made the comment and the resident denied making the comment.

Interview with the SW by Inspector #111 confirmed, on a specified date, the SDM reported an allegation of staff to resident abuse towards resident #021 by PSW #125. The SW was not aware of when the alleged staff to resident abuse incident actually occurred. The SW indicated no awareness that the investigation forms were to be completed as per the home's policy. The SW indicated the DOC had reminded the SW to complete the investigation forms, a number of days later. The SW indicated the allegation was reported to the RCM's the same day the allegation was received.

The licensee failed to follow the Zero Tolerance of Abuse and Neglect policy as: the

PSW #125 who was involved in the allegation, continued to work and provide care to residents the day the allegation was made and was not relieved of duty until the following day. The SW who received the allegation did not complete the Incident Investigation Form until a number of days after the allegation was made and did not complete all the required information. The SW notified RN #148 and RCM #108 via email, which was not received by the RCM #108 and the DOC until the next day (despite both of them working at the time the email was sent). The investigation did not include statements from all staff who were aware of the allegation (RPN #147 and RN #148). The RCM did not complete the Incident Investigation Form until a number of days later, despite becoming aware of the allegation the day after the allegation was made and the form did not have all the required information completed. The investigation never indicated when the incident actually occurred.

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

Related to Log # 004739-18:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, the SW was notified by the SDM of resident #021, that PSW #125 had been abusive towards the resident. The SDM indicated the resident was very uncomfortable as a result. The CIR was completed by RCM #108.

Review of the home's investigation into the allegation of staff to resident abuse involving resident #021 indicated the SW spoke to the resident on a specified date, regarding the residents reports of improper care by staff on a specified shift. During that time, the SDM of resident #021 informed the SW that a staff member had confronted the resident regarding the allegations (PSW #125). The investigation was not initiated until the day after the allegation was made.

The licensee has failed to ensure that an alleged staff to resident abuse was immediately investigated.

2. The licensee has failed to ensure that the outcome of the abuse investigation were reported to the Director.

Related to Log # 003994-18:

A critical incident report (CIR) was submitted to the Director for a suspected resident to resident abuse incident. The CIR indicated on a specified date and time, PSW #144 heard a verbal altercation between resident #029 and resident #030. The PSW entered the room and intervened. Resident #030 reported resident #029 engaged in a verbal and physical altercation with the resident which resulted in pain and injury to a specified area to resident #030. The CIR was completed by RCM #128.

Interview with RCM #128 by Inspector #111, confirmed the CIR was not amended to indicate the outcome of the investigation.

Interview with the DOC by Inspector #111, confirmed the Director was not provided the results of the investigation for the resident to resident abuse.

The licensee has failed to ensure that the results of the investigation into resident to resident abuse, involving resident #029 and #30, were reported to the Director.

3. The licensee has failed to ensure that the outcome of the abuse or neglect investigation were reported to the Director.

Related to Log # 002375-18:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, a staff to resident verbal abuse incident involving resident #025 was reported to RN #127. The CIR did not indicate the outcome of the investigation. The CIR was completed by RCM # 128.

Interview with RCM #128 by Inspector #111, indicated the alleged staff to resident abuse involving resident #025 was investigated and determined to be unfounded the day after

outcome of the investigation.

Interview with the DOC by Inspector #111, confirmed the Director was not made aware of the outcome of the investigation.

The licensee has failed to ensure that the results of the investigation, into alleged staff to resident abuse involving resident #25, was reported to the Director.

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 alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that has been reported, is immediately investigated, 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 :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was 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 risk of harm.

Related to Log # 004739-18:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, the SW was notified by the SDM of resident #021, that PSW #125 had been abusive to the resident. The SDM indicated the resident was very uncomfortable as a result of the incident. The CIR was completed by RCM #108.

Interview with the SW by Inspector #111, indicated the Director was notified of the alleged staff to resident abuse the day the CIR was submitted to the Director. The SW confirmed the SW did not report the allegation to the Director immediately but notified the RCMs via email.

Interview with RCM #108 by Inspector #111, indicated the RCM became aware of the alleged staff to resident abuse incident involving resident #021 with PSW #125, the day after the allegation was made. The RCM confirmed the allegation was reported to the Director at that time.

Interview with the DOC by Inspector #111, indicated the expectation is that the person who discovers the allegation, should notify the Director or immediately, or immediately inform either RCMs or the DOC, to ensure the Director is notified and not via email. The DOC confirmed the alleged staff to resident abuse incident involving resident #021 and PSW #125 was not immediately reported to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of resident #021 by PSW #125 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

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 a person who had reasonable grounds to suspect that abuse of a resident by a staff member that resulted in risk of harm had occurred, immediately reported the suspicion and the information upon which it was based, to the Director, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log # 002375-18:

A critical incident report (CIR) was submitted to the Director for an alleged staff to resident verbal abuse incident. The CIR indicated on a specified date and time, resident #025 reported to RN #127 that a staff member was abusive towards the resident, when the resident complained about improper care. The CIR indicated the SDM was notified of the allegation but there was no indication the SDM was notified of the outcome of the investigation. The CIR was completed by RCM #128.

Review of the home's investigation into the alleged staff to resident abuse indicated, the investigation was concluded on a specified date and there was no documented evidence of the outcome of the investigation or to indicate the SDM was notified of the outcome.

Interview with RCM #128 by Inspector #111, indicated the RCM became aware of the alleged staff to resident abuse on a specified date and determined the allegation was unfounded. The RCM confirmed the SDM was not informed of the outcome of the investigation into the alleged staff to resident abuse.

Interview with the DOC by Inspector #111 confirmed the allegation was determined to be unfounded and also confirmed the SDM was not informed of the outcome of the investigation upon its completion.

The licensee has failed to ensure that resident #025's SDM was notified of the results of the alleged abuse investigation immediately upon the completion.

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 resident and the resident;s SDM are notified of the results of alleged abuse or neglect immediately upon completion of the investigation, to be implemented voluntarily.

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.