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_0019	006706-18, 018381-18, 020041-18, 020157-18, 024722-18, 024723-18, 024724-18	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

LYNDA BROWN (111)

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

There were seven complaints completed concurrently during this inspection:
-Log # 024723-18, 024722-18, 024724-18, 006706-18, 020157-18 were related to bed refusals,
-Log # 020041-18 was related to alleged staff to resident abuse,
-Log # 018381-18 was related to alleged improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Community Care Access Centre (CCAC), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the Placement Coordinator (PC).

During the course of the inspection, the inspector reviewed admission packages from the CCAC, reviewed the home's investigation into alleged abuse, reviewed the health care records of two residents, observed and interviewed residents and reviewed the Complaints policy.

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others, who provide direct care to the resident.

Related to Log # 018381-18:

An anonymous complaint was received regarding resident #002, indicating concerns the resident was not being showered or shaved.

Observation of resident #002 on a specified date and time, by Inspector #111, indicated the resident was clean and well groomed. The resident was not interviewable.

Review of the current written care plan for resident #002 indicated under bathing: required assistance by providing supervision and verbal cues during bathing and preferred two showers per week, on two specified days. Under hygiene: required assistance for personal hygiene for grooming daily by providing constant supervision, cueing with physical assistance and reminder to groom daily.

Review of the bathing schedule for resident #002 indicated the resident was scheduled for a shower on two specified days and at two specified times.

Interview with Registered Nurse (RN) #110 by Inspector #111, indicated that the Personal Support Worker's (PSW's) documented bathing and grooming in Point of Care (POC). The RN indicated the regular scheduled bathing was indicated on the 'q shift' report and any additional bathing (when the resident either refuses or not available for the scheduled task) was indicated on the as needed (PRN) report to indicate when an alternate bathing/grooming time/date is offered and provided.

Interview with PSW #119 by Inspector #111, indicated was assigned to provide care to resident #002. The PSW indicated the resident was independent with personal care and required set up only, for the resident to complete the task. The PSW indicated the resident preferred to have two showers per week and required staff assistance with a portion of the shower, but otherwise the resident completed the rest of the shower independently. The PSW indicated the resident recevied two showers per week as scheduled and received additionally up to four or five showers per week, as per resident request. The PSW indicated the resident was frequently unavailable during specified times of the day.

Interview with RPN #121 and PSW #120 by Inspector #111, both indicated resident #002 liked to have daily showers at specified times. They both indicated the resident was unavailable on a daily basis.They were both aware of the resident's scheduled shower days/ times and indicated the resident would frequently miss one of their shower days due to the specified times the shower was scheduled.

Review of the POC for a specified period for resident #002 under bathing/grooming indicated: the resident received their shower/grooming on one of the specified days/times per week, but usually either refused or was not available for the second weekly shower/grooming due to specified time the shower/grooming was scheduled. The resident received additional showers/grooming on alternate days/times on the PRN report. The resident did not receive more than two showers/week.

Review of the progress notes for resident #002 indicated on a specified date and time, the Substitute Decision Maker (SDM) was upset the resident had not received a shower and grooming at least twice weekly on the specified dates and times. The SDM also indicated that the resident required assistance to complete the task as the resident was not capable of completing the task independently.

The plan of care did not give clear direction related to showers/grooming, as the plan of care offered a second shower per week, when the resident was known by staff to be out on LOA's (and despite the SDM request for the showers to be provided at specified times due to the LOA's). The plan of care also indicated the resident only required set up for grooming despite the resident not independently grooming self without staff assistance.

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.