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
Mar 15, 2019	2019_640601_0006	008792-18, 008816-18, 008981-18, 010362-18, 012243-18, 013031-18, 013452-18, 025920-18, 026621-18, 027913-18, 029853-18, 031460-18, 031855-18, 032496-18, 032756-18, 033066-18, 000122-19, 000434-19, 001525-19, 002931-19, 003063-19, 004029-19	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

KARYN WOOD (601), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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 14, 15, 19, 20, 22, 26, 28 and March 1, 2019.

Log #031855-18 related to a follow up inspection s. 19. (1), duty to protect.

Log #013031-18, log #029853-18, log #033066-18, and log #000434-19 related to a fall.

Log #027913-18 related to outbreak management.

Log #010362-18, log #012243-18, log # 031460-18, log #002931-19 related to allegations of resident to resident abuse.

Log #008792-18, log #008816-18, log #008981-18, log #013452-18, log #025920-18, log #026621-18, log #032496-18, log #032756-18, log #000122-19, log #004029-19, log #001525-19, log #003063-19 related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with with the Executive Director, the Director of Care (DOC), Resident Care Manager (RCM), Resident Care Supervisor (RCS), Registered Nurses (RN), Registered Practical Nurses (RPN), Social Service Worker (SSW), Physiotherapist (PT), Personal Support Workers (PSW), Behavioural Support Ontario (BSO), Dietary Aide, (DA), Public Health Nurse and residents.

The inspectors also reviewed residents' health care records, the licensee's relevant policies and procedures, staff education records, and observed the delivery of resident care and services, including resident-staff interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_603194_0018	194

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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #017's plan of care related to transfers was provided to the resident, as specified in the plan.

Related to log #032496-18:

On a specified date and time, Critical Incident Report (CIR) was submitted to the Director, by Resident Care Manager (RCM) #115. The CIR indicated that on a specified date and time resident #017 reported allegations of abuse to PSW #120 and PSW #116 while they were assisting resident #017 with care. The CIR further indicated that PSW #119 had provided resident #017's care on the specified date and time of the allegations of resident abuse.

Inspector #601 reviewed the licensee's investigation interview between RCM #115 and PSW #119, regarding the allegations of resident abuse for the incident that occurred on a specified date and time. According to RCM #115's investigation notes, PSW #119 had indicated to RCM #115 that on a specified date and time, resident #017 was transferred out of bed with the assistance of one person.

Record review of resident #017's care plan at the time of the incident, by Inspector #601 identified that resident #017 was able to weight bear, required assistance for transferring from one position to another. Resident #017 had a goal to receive the necessary assistance and the transfer care plan interventions included:

-Two person transfer with a mechanical device.

Record review of resident #017's Safe Resident Handling Assessment with a specified date, by Inspector #601 identified that the resident required a mechanical device for all transfers.

During a telephone interview, PSW #119 indicated to Inspector #601 that on the specified date, they had transferred resident #017 by themselves without the aid of a mechanical device. PSW #119 further indicated they were not aware that the resident's transfer status had been changed to a mechanical device.

During an interview with Inspector #601, RCM #115 indicated that resident #017's care plan indicated resident #017 required two people with the mechanical device for all transfers. RCM #115 also reviewed the resident's Safe Resident Handling Assessment with a specified date and this indicated that resident #017 required the mechanical device with two people for all transfers. RCM #115 further indicated to Inspector #601 that PSW #119 did not follow resident #017's plan of care when they transferred the resident with one person, on the specified date and time.

The licensee did not ensure that resident #017's was transferred using the mechanical device with two people on the specified date and time, as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that when a resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care.

Related to log #012243-18:

On a specified date, an after hours call was received reporting an altercation between resident #005 and resident #006.

On the following day, Critical Incident Report (CIR) was submitted to the Director reporting that on a specified date and time, resident #005 and resident #006 were passing each other in the hallway of the home area, when the identified altercation occurred between resident #005 and resident #006. The residents were separated by staff. Resident #006, was assessed and it was noted the resident had sustained an injury to a specified location.

On a specified date, the increased monitoring of resident #005, which had been initiated

after a previous incident with resident #006, was discontinued as resident #005 had not displayed any of the identified responsive behaviours. Due to the incident on the specified date, increased monitoring for resident #005 was initiated again.

Review of resident #005's plan of care related to identified responsive behaviours with a specified date post incident indicated:

Problematic manner in which resident #005 acts characterized by identified responsive behaviours related to predictable situations.

Triggers related to resident #005's responsive behaviours were identified with a goal to reduce incidents.

Specific Interventions were included in the plan of care to reduce incidents of responsive behaviours.

On a specified date and time in separate interviews, Inspector #166, interviewed Registered Practical Nurse (RPN) #104, PSW #105 and BSO #106, who all indicated that resident #005 no longer displayed any of the identified responsive behaviours towards co-residents.

Review of clinical records from a specified date until the date of this inspection, indicated that resident #005 continued to have five incidents of an identified behaviours directed towards co-residents post incident.

Review of resident #005's responsive behaviour plan of care, for two specified months and including the Care Tip Sheet updated last on a specified date, did not reflect any evidence that different approaches had been considered in the plan when resident #005 continued to display the identified responsive behaviour towards co-residents.

The licensee failed to ensure that when resident #005 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective that different approaches were considered in the revision of resident #005's plan of care. [s. 6. (11) (b)]

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 care set out in resident #017's plan of care related to transfers is provided to the resident, as specified in the plan and that resident #005 is being reassessed and the plan of care is being revised when the care set out in the plan has not been effective, and that different approaches have been considered in the revision of the plan of care, 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 their policy to promote zero tolerance of abuse and neglect was complied with.

The licensee's prevention of abuse policy titled "Zero Tolerance of Abuse, #RCM-RR-590", last revised on a specified date, indicated that it was mandatory that all staff report any act, report of act, or allegation of resident abuse to a member of the registered staff or management team, as soon as the incident occurs. The policy also outlined that in the event of any alleged incident of resident abuse, the registered staff or manager would notify the Ministry of Health and Long Term Care immediately and document in Point Click Care.

Related to log #008792-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the

Director, by Resident Care Manager (RCM) #115. The CIR was reviewed by Inspector #601 and it was identified that on a specified date, resident #011 reported to Social Service Worker (SSW) #136 allegations of resident abuse. The investigation concluded that there was no finding to support abuse towards resident #011.

During a telephone interview, the Social Service Worker (SSW) #136 indicated to Inspector #601 that on a specified date, resident #011 had reported allegations of abuse regarding the care that had been provided. SSW #136 further indicated that they informed RCM #115 of the allegations of abuse the following morning. SSW #136 indicated they should have notified the registered nurse or manager when the allegations of abuse were brought to their attention.

During an interview, the Resident Care Manager (RCM) #115 indicated to Inspector #601 that the allegations of abuse was reported to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, when the incident regarding resident #011 was brought to their attention. RCM #115 further indicated that SSW #136 should have notified the registered nurse or manager as directed in the Zero Tolerance of Abuse policy when the allegations of abuse were brought to their attention.

The licensee did not comply with their policy titled "Zero Tolerance of Abuse, #RCM-RR-590", when SSW #136 who suspected an alleged abuse did not immediately report the incident to the registered staff or manager, as specified in the licensee's policy.

Related to log #008816-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the Director, by RCM #115. The CIR report indicated that on a specified date, the Maintenance Worker (MW) #141 observed resident #012, RPN #140, PSW #142 and PSW #143 at a specified location. According to the CIR, the MW #141 witnessed alleged abuse towards resident #012 by RPN #140, on a specified date. On a specified date and time, four days following the witnessed incident, MW #141 informed the Director of Care (DOC) of the allegations of resident abuse. The investigation concluded that the resident had no recollection of the event and that there was no finding to support a claim of abuse towards resident #012.

During an interview, RCM #115 indicated to Inspector #601 that the allegations of abuse were reported to the Ministry of Health and Long-Term Care (MOHLTC) when the incident was brought to their attention, on a specified date. RCM #115 further indicated

that MW #141 informed the DOC and DOC immediately notified RCM #115. RCM #115 also indicated that MW #141 should have notified the Environmental Service Manager, registered practical nurse, registered staff or manager as directed in the Zero Tolerance of Abuse policy, when the allegations of abuse were witnessed by MW #141 on a specified date.

The licensee did not comply with their policy titled "Zero Tolerance of Abuse, #RCM-RR-590", when MW #141 witnessed suspected or alleged abuse did not immediately report the incident to the registered staff or manager immediately, as specified in the licensee's policy.

Related to log #025920-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the Director, by RCM #107. The CIR indicated that on a specified date and time, PSW #150 had allegedly abused resident #015. According to the CIR, on a specified date and time, RPN #151 witnessed PSW #150 allegedly abuse resident #015, when they requested assistance with care. The investigation concluded that resident #015 was not upset about the incident and there was no findings to support a claim of resident abuse towards resident #015, on the specified date.

During an interview, the Resident Care Manager (RCM) #107 indicated to Inspector #601 that the allegations of abuse were reported to the Ministry of Health and Long-Term Care (MOHLTC) the following day, when the incident involving resident #015 was brought to their attention. RCM #107 further indicated that RPN #151 had reflected on the incident involving resident #015 and PSW #150. RPN #151 informed RCM #107 of the allegations of abuse on a specified date. RCM #107 further indicated that RPN #151 should have notified the registered nurse immediately on a specified date, when they witnessed the allegations of resident abuse.

The licensee did not comply with their policy titled "Zero Tolerance of Abuse, #RCM-RR-590", when RPN #151 who witnessed suspected or alleged abuse did not immediately report the incident to the registered staff or manager, as specified in the licensee's policy.

Related to log # 013452-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the

Director, by RCM #115, The CIR was reviewed by Inspector 601 and it was identified that on a specified date, DA #162 informed PSW #163 that they had witnessed an alleged resident abuse involving resident #014 and PSW #113. On a specified date, PSW #163 reported the allegations of resident abuse to RCM #115.

During an interview, RCC #115 indicated to Inspector #601 that the allegations of abuse were reported to the Ministry of Health and Long-Term Care (MOHLTC) when the incident was brought to their attention, on a specified date and time. RCM #115 further indicated that DA #162 should have notified the Dietary Manager, registered practical nurse, registered staff or manager when the allegations of abuse was witnessed, on a specified date and time.

The licensee did not comply with their policy titled "Zero Tolerance of Abuse, #RCM-RR-590", when the staff member who witnessed suspected or alleged abuse did not immediately report the incident to the registered staff or manager, as specified in the licensee's policy. [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 to ensure that the policy to promote zero tolerance of abuse is complied with, 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 failed to ensure the Director was informed immediately of the suspicion of a resident being emotionally abused and neglected.

The licensee's prevention of abuse policy titled "Zero Tolerance of Abuse, #RCM-RR-590", last revised on a specified date, indicated that it was mandatory that all staff report any act, report of act, or allegation of resident abuse to a member of the registered staff or management team, as soon as the incident occurs. The policy also outlined that in the event of any alleged incident of resident abuse, the registered staff or manager would notify the Ministry of Health and Long Term Care immediately and document in Point Click Care.

Related to log #008981-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the Director, by RCM #115. The CIR report indicated that on a specified date and time, resident #013 reported to RPN #147 the allegations of resident abuse. The CIR further indicated that RPN #147 reported the allegations to RN #148 immediately. According to the CIR, RN #148 was not able to speak with resident #013 at this time, as the resident was sleeping when the RN went to the resident's room. The CIR further indicated that the following evening, on a specified date, RN #148 had spoken with resident #013 and informed the DOC of the allegations of resident abuse. The DOC was informed on a

specified date and then immediately notified RCM #115.

During an interview, the Resident Care Manager (RCM) #115 indicated to Inspector #601 that the allegations of abuse were reported to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date, when the incident involving resident #013 was brought to their attention. RCM #115 further indicated that RN #148 should have notified the MOHLTC when the allegations of abuse were brought to their attention by RPN #147 on a specified date.

The licensee failed to ensure that the incident of alleged resident abuse that occurred on a specified date and time was immediately reported to the Director, as required. RN #148 was made aware of the incident of alleged resident abuse by RPN #147 on a specified date and the allegation of abuse was not reported to the Director under the LTCHA, until two days after the incident occurred.

Related to log #032496-18:

On a specified date and time, a Critical Incident Report (CIR) was submitted to the Director, by Resident Care Manager (RCM) #115. The CIR indicated that on a specified date and time, resident #017 reported allegations of abuse to PSW #120 and PSW #116 while they were assisting the resident with their care. The CIR further indicated that PSW #120 immediately reported the allegations to RPN #121. Upon becoming aware of the incident, RPN #121 spoke with the resident about the allegations and informed RCM #115 and provided the information reported by resident #017. According to the CIR, RCM #115 submitted the CIR to the Director two days after the incident when they were made aware of the allegations. The investigation concluded that there was no finding to support a claim of abuse towards resident #017.

During an interview, the Resident Care Manager (RCM) #115 indicated to Inspector #601 that the allegations of abuse were reported to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date and time, when the incident involving resident #017 was brought to their attention. RCM #115 also indicated that the internal investigation determined that RPN #121 felt that the comments made by the resident were behavioural and RPN #121 did not suspect resident abuse. RCM #115 further indicated that PSW #120 had reported the allegations of abuse to RN #122 on the following day and RN #122 requested PSW #120 to complete an abuse incident form. RCM #115 indicated that RN #122 should have notified the MOHLTC when they suspected allegations of abuse and when the allegations were brought to their attention by PSW #120.

The licensee failed to ensure that the incident of alleged abuse that occurred on a specified date and time and was immediately reported to the Director, as required. RN #122 was made aware the incident of alleged abuse on a specified date and time and the allegation of abuse was not reported to the Director under the LTCHA, until the following day.

Related to log #000122-19:

On a specified date and time, a Critical Incident Report (CIR), was submitted to the Director, by RCM #115. Inspector #601 reviewed the CIR and the CIR indicated that on a specified date and time, resident #019's Substitute Decision Maker (SDM) had contacted RPN #126 by telephone to report the allegation of resident abuse. According to the CIR, RPN #126 reported the incident to RN #127 and also informed the DOC, RCM#107 and RCM #115. The investigation concluded that there was no harm to the resident and there was no finding to support a claim of resident abuse.

During an interview, RPN #126 indicated to Inspector #601 that resident #019's SDM had brought forward the allegations of abuse on a specified date and time. RPN #126 reported that they immediately informed RN #127 of the allegations of resident abuse, they completed the abuse incident form, the allegations of abuse were documented in PCC and the DOC, RCM #107 and RCM #115 were informed.

During an interview, RN #127 indicated to Inspector #601 that RPN #126 had made them aware of the allegations of abuse that resident #019's SDM reported on the specified date. RN #127 further indicated that they should have notified the manager and the MOHLTC immediately when the allegations of resident abuse were brought to their attention, by RPN #126.

During an interview, the Resident Care Manager (RCM) #115 indicated to Inspector #601 that the allegations of abuse was reported to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date and time, when the incident regarding resident #019 was brought to their attention. RCM #115 further indicated that RN #127 should have immediately notified the MOHLTC when the allegations of abuse were brought to their attention on a specified date.

The licensee failed to ensure that the alleged resident abuse was immediately reported to the Director, as required. RN #127 was made aware of the alleged emotional resident

abuse on a specified date and time and the allegation of resident abuse was not reported to the Director under the LTCHA, until the following day. [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 to ensure the Director is informed immediately of the suspicion of a resident being abused, to be implemented voluntarily.

Issued on this 3rd day of April, 2019

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

Original report signed by the inspector.