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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 11, 2019	2019_694166_0005	027655-18, 030443-18, 031474-18, 031644-18	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

CAROLINE TOMPKINS (166), 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): February 14, 15, 19, 20, 22, 26, 28, March 1, 2019.

Complaint log #031644-18, related to a resident's fall, cross referenced with log #031474-18, critical incident report #M520-000056-18 related to the same fall, complaint log #030443-18 related to the management of responsive behaviours and complaint log #027655-18 related to the management of complaints were inspected concurrently during this inspection

During the course of the inspection, the inspector(s) spoke with Family, Residents, Physician, Executive Director(ED), Director of Care(DOC), Resident Care Managers (RCM), Registered Nurses(RN), Registered Practical Nurse(RPN) and Personal Support Workers(PSW).
During the course of this inspection the Inspectors reviewed clinical documentation, the licensee's investigation documentation, the licensee's complaint process and relevant policies related to this inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Responsive Behaviours

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 license has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Related to Logs #031644-18 and #031474-18:

On a specified date, a complaint was submitted to the Director, expressing concerns related to the fall and the management of the fall for resident #003.
Review of the complaint documentation indicated that on the specified date when resident #003 fell, the complainant alleged the staff felt the fall was minor and did not take any action, did not notify the doctor and did not appropriately assess the resident. The complainant indicated the fall was ignored and as a result, the resident subsequently required further treatment.

Review of clinical documentation related to resident #003's fall indicated: Immediately after resident #003 fell and was assessed by RPN #100, the resident continued to independently mobilize within the home area accompanied by the resident's Substitute Decision Maker (SDM), who had been made aware of the fall. The resident did not display any indication of difficulty or discomfort while mobilizing. The resident's physician was notified of the fall by notation in the physician's communication.

Each day post incident, the resident's condition changed and the resident was not able to be independently mobile. The resident's status was noted in the doctor's book and an

email was sent to the Physiotherapist and the Registered Nurse was updated.

Documentation related to resident #003's status indicated the resident was in moderate discomfort and also experienced discomfort with care. Analgesic was given with good effect. The on call physician was notified. An order was received for the resident to receive a mobile diagnostic test.

Resident #003 was examined by the physician, who ordered an as needed analgesic to control the resident's discomfort. The physician then met with the resident's family to discuss the resident's physical status, treatment and medication routine.

Documentation related to the resident's status indicated resident #003, presented with symptoms of being unwell. Verbal and facial expressions indicated resident was experiencing discomfort with movement. Resident #003's family member was informed of the resident's change in condition. The resident was transferred to the hospital for further assessment and treatment.

During an interview with Inspector #166, the DOC indicated, that when any resident has a change in condition the Registered Nurse (RN) is to be made aware and the RN is to complete an assessment of that resident.

During an interview with Inspector #166, RN #105, and Inspector #166 were unable to find any documented evidence that a Registered Nurse had assessed resident #003, related to a change in condition, when resident #003 initially began to have difficulty mobilizing and experienced increased discomfort.

A review of clinical documentation and interviews with the DOC and RN #105 indicated that the licensee failed to ensure the Registered Practical Nurses (RPN) and the Registered Nurses (RN) collaborated with each other related to the assessment of resident #003, when the resident had an initial change of condition.

The license has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.[s. 6 (4)] (166).

Related to Logs #031644-18 and #031474-18:

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A complaint was submitted to the Director, expressing concerns related the fall and the management of the fall for resident #003.

Review of the complaint documentation indicated on the specified date when resident #003 fell, the resident was to be monitored one to one by a staff assigned specifically to resident #003.

Review of resident#003's plan of care, indicated, to ensure the safety of resident #003 and others, one to one monitoring was initiated on specifically identified shifts
During separate interviews with Inspector #166, the DOC, RCM #111 and RPN #100 and review of resident #003's plan of care indicated the responsibility of a staff member assigned to monitor a specific resident is to ensure that the resident is always within eyesight and within arm's length of the monitoring staff member. This is a prevailing practice within the home.

Review of the licensee's investigation and witness statements indicated, at the time of resident #003's fall, the staff member assigned to monitor the resident was not within eyesight and within arm's length of resident #003.
During an interview with Inspector #166, PSW #109, who was the staff member assigned to monitor resident #003, confirmed they were not within eyesight and arm's length of the resident at the time the resident fell.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in plan. [s. 6. (7)] (166)

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 the plan of care is provided to residents as specified in the plan and that the staff, specifically the registered staff, involved in the different aspects of care of residents, collaborate with each other, in the assessment of residents so that their assessments are integrated and are consistent with and complement each other especially when there is a change in a resident's condition, to be implemented voluntarily.

Issued on this 2nd day of April, 2019

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

Original report signed by the inspector.