Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 25, 2021	2021_815623_0014	025833-20, 000563-21, 007619-21, 007888-21	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

SARAH GILLIS (623)

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): June 2-4, 7-10, 2021

The following intakes were inspected concurrently:
A Critical Incident Report for an allegation of staff to resident neglect
Two Critical Incident Reports for a fall with injury
A Critical Incident Report for an incident that caused injury to a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Resident Care Managers (RCM), Resident Care Supervisors (RCS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT) and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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)**

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for resident #004, was provided to the resident as specified in the plan.

Resident #004's written care plan indicated that the resident required specific interventions with two staff with all aspects of an identified activity of daily living (ADL). The plan of care also indicated that the resident required hourly checks for safety. On an identified date PSW #118 and #120 set resident resident #004 up for a specific ADL, using the mechanical lift. PSW #120 left the resident with PSW #118 while they attend to other residents and was not asked to assist PSW #118 to assist with resident #004 again. Resident #004 was discovered several hours later by PSW #117, where they had been left by PSE #118 and #120. The licensee's internal investigation determined that the resident had been left unattended, for several hours.

During separate interviews PSW #117 and PSW #120 indicated that resident #004 should not be left unattended when set up for a specific ADL. Staff should remain within the residents' room or the adjoining room so that the resident could be visualized for safety. PSW #117 and #120 indicated that resident #004 would not be able to ring the call bell for assistance. PSW #120 indicated that they believed PSW #118 would remain with the resident and call for assistance when they were ready.

Resident #004 was at risk when the plan of care was not followed, when the resident was left unattended for several hours and safety checks were not completed hourly.

Sources: licensee's internal investigation, clinical records, observations of resident #004, interview with PSW #117 and PSW #120. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

Issued on this 13th day of July, 2021

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

Original report signed by the inspector.