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 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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016	2016_328571_0018	018889-16; 017240-16	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
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

PATRICIA MATA (571)

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 28, 29 and 30, 2016.

The following Critical Incident Report Logs were inspected:
018889-16 related to resident to resident abuse and 017240-16 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the interim Director of Care, Resident Care Manager, Registered Practical Nurses, Personal Support workers, members of the Behavioural Support Ontario team and residents.

In addition, the following was reviewed: resident clinical records, nursing reports, the licensee's investigation records and the licensee's Zero Tolerance of Abuse and Neglect Policy.

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

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	Legendé 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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director (MOHLTC) was made within 10 days of becoming aware of the alleged emotional abuse of resident #004 by a staff member.

A report was made to the Director on a specified date when the licensee became aware of the alleged emotional abuse of resident #004 by a staff member. This report was made via the after hours pager.

The report indicated that on a specified date, the acting Director of Care was informed of an incident of alleged emotional abuse of resident #004 by a staff member two days previously. The report indicated that resident #004, who was eating in his/her room, alleged that a staff member insisted the resident stay up to eat supper. The resident wanted to go to bed. The resident alleged that he/she was not helped to bed.

In an interview on June 29, 2016, the Director of Care indicated that the incident was immediately reported and investigated when the home became aware on a specified date but that evidence of a Critical Incident Report (CIR) being submitted could not be found. A CIR was submitted on June 29, 2016, after the home became aware of the omission.

Therefore, the CIR was submitted for an allegation of emotional abuse more than 10 days after the licensee became aware of the incident. [s. 104. (2)]

Issued on this 18th day of July, 2016

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

Original report signed by the inspector.