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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Dec 23, 2016	2016_389601_0029	013466-16	Resident Quality Inspection

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

KARYN WOOD (601), BAIYE OROCK (624), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 1, 2, 3, 4, 7 and 8, 2016.

The following Critical Incidents Reports (CIR) were included in this inspection:

Log #021151-16, log #026451-16 and log #030825-16 related to a resident fall that resulted in an injury.

Log #023903-16, log #028864-16, log # 030005-16, log #030088-16 and log #030165-16 related to allegations of resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Chief Executive Officer (CEO), Chief Wellness Officer (CWO), Resident Care Manager (RCM), Resident Care Supervisor (RCS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident and Family Council representatives.

During the course of the inspection, the inspectors conducted a full walking tour of the home, reviewed resident health care records and the licensee policies related to fall prevention and abuse, observed interactions between staff to residents and resident to resident, medication administration, medication storage and infection control practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
2 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 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 has failed to ensure that the care set out in the plan of care related to continence for resident #021 was provided to the resident as specified in the plan.

Log #023903-16 involving resident #021:

Inspector #194 reviewed resident #021's clinical health records and identified that resident #021 required two staff for continence assistance.

Review of the Critical Incident Report (CIR) and internal investigation by the home confirmed that PSW #101 was approached on three occasions within a ten minute period to provide continence care to resident #021.

During an interview, PSW #101 indicated to inspector #194 that on the identified date resident #021's Substitute Decision Maker (SDM) approached the staff, after activating the resident-staff communication and response system (call bell) to have continence care for resident #021 provided. PSW #101 indicated that the call bell was turned off and returned to the desk to continue documentation, as the other co-workers on the unit were busy completing care. PSW #101 indicated to Inspector #194 that resident #021's continence care could not be provided as the resident was a two staff assist and there was no other staff available.

During the same interview, PSW #101 indicated to Inspector #194 that a few minutes later, the call bell for resident #021 was engaged. PSW #101 indicated returning to resident #021's room at this time. PSW #101 indicated turning off the call bell at this time and returned to the desk to continue documentation.

Inspector #194 reviewed the CIR submitted to the Director by RCM #106 and identified that resident #021's SDM came to the nursing station asking for staff to provide

continence care for resident #021. PSW #101 indicated to SDM that the following shift would be able to complete the care, as there was only six minutes left for the shift and there was no other staff available to assist with the care. Resident #021 waited thirty-five minutes and to be provided continence care.

Inspector #194 reviewed the plan of care for resident #021 related to continence care and identified that resident #021 was to receive continence care every four hours and as required. Resident #021's SDM expressed the need for resident #021 to receive continence care on three separate occasions. Resident #021 waited thirty-five minutes and to be provided continence care. [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 to ensure that the care set out in the plan of care related to continence for resident # 021 is provided to the resident as specified in the plan, 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 policy "Zero Tolerance of Abuse and Neglect" RCM-RR-590 dated September 15, 2016 was complied with for resident #022.

Log #028864-16 involving resident #022:

Review of the Zero Tolerance of Abuse and Neglect RCM-RR-590 policy was completed by Inspector #194 and directed staff:
-Upon Fairhaven becoming aware of other alleged, suspected or witnessed incident of abuse or neglect of the resident the SDM will be notified within 12 hours and upon completion of the investigation.

-In the event of any alleged incident of resident abuse, the Registered staff/Management Team will notify Ministry of Health and Long Term Care immediately and document in PCC.

During an interview the Chief Wellness Officer (CWO) explained to Inspector #194 that the policy statement above implies the Ministry was to be notified as directed in the legislative requirements including notification of the Director after the completion of the investigation and further explained that a check list is provided to the Management Team where notification of the Director with results of the investigation was noted.

Review of the CIR submitted to the Director indicated that PSW #104 reported allegations of staff to resident physical abuse to the RPN. The outcome of the investigation determined that resident #022 was not harmed. During an interview with inspector #194, RCM #106 indicated that the Director and SDM of resident #022 had not been informed of the outcome of the licensee's internal investigation. [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 policy "Zero Tolerance of Abuse and Neglect" RCM-RR-590 dated September 15, 2016 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that results of the abuse investigation were reported to the Director.

Log #028864-16 involving resident #022:

Inspector #194 reviewed the CIR submitted to the Director and identified that PSW #104 reported allegations of staff to resident physical abuse to the RPN. During an interview with inspector #194, RCM #106 indicated that the results of the abuse investigation were not reported to the Director. [s. 23. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was notified of the results of the alleged abuse investigation immediately upon the completion.

Log #028864-16 involving resident #022:

Inspector #194 reviewed the CIR submitted to the Director and identified that PSW #104 reported allegations of staff to resident physical abuse to the RPN. The licensee's internal investigation determined that resident #022 was not harmed.

During an interview on with inspector #194, RCM #106 indicated that the SDM of resident #022 had not been informed of the outcome of the licensee's internal investigation. [s. 97. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to notify the Director within one business day for an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change of resident #030's health condition.

Log #030825-15 involving resident #030:

Inspector #194 reviewed the CIR submitted to the Director and identified that resident #030 suffered a fall which resulted in resident #030 being transferred to hospital for further assessment. The resident was assessed at the hospital with an injury resulting in a significant change in condition. The progress notes for resident #030 indicated that the family contacted the home to inform them of the resident's condition later in the evening.

During an interview, RCM #106 indicated being aware that the reporting timelines to the Director were missed but did not have any explanation for the delay in reporting.

The CIR was submitted to the Director two days after the incident. [s. 107. (3.1)]

Issued on this 23rd day of December, 2016

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

Original report signed by the inspector.