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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2018	2018_603194_0018	001849-18, 004738-18, 004829-18, 006897-18, 008719-18	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

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): September 12, 13, 14, 17, 18 19, 20, 21, 2018

The inspector inspected the following Critical incidents; Log #001849-18, Log #004738-18, Log #004829-18, Log #006897-18 for allegations of resident to resident sexual abuse as well as Log #008719-18, for allegations of staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Behavioural Support Ontario (BSO)/RPN, Registered Physio Therapist (RPT), Physio Therapist Aide (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Resident Care Coordinators (RCM) and Residents

The inspector observed the provision of staff to resident care, reviewed relevant policies related to pain and abuse, staff educational records, internal investigation documentation, clinical health records of identified residents and BSO documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Every licensee of a long term care home shall protect residents from abuse by anyone

and shall ensure that resident are not neglected by the licensee or staff.

The Definition of Neglect under O. Reg. 79/10 s. 5; Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being or one or more residents.

Related to Log # 008719-18:

A Critical incident Report was submitted on an identified date to report an allegation of staff to resident abuse, resulting in an injury to resident #022.

The plan of care for resident #022 prior to an identified dated indicated that the resident was noted to be able to express when having pain, required a mobility device for mobility requiring staff assistance at times, transfer and toileting were completed with two staff assistance. The plan of care for resident #022 indicated that no assistance was required with dressing or eating. Resident #022 died on an identified date, of unrelated circumstances.

The licensee's internal investigation statements, CIR, and progress notes indicated that on an identified date, resident #022 stated that PSW #132 was assisting with care when the resident experienced pain. The evidence reviewed indicated that resident #022 did not report the incident until a number of days later.

The licensee's internal investigation statements for PSW #132 indicated that resident #022 did express pain when care was provided and again when being transferred. PSW #132 also stated that resident #022 expressed pain during provision of care. PSW #132 also indicated that RPN #134 was present during the transfer of resident #022.

During telephone interview with inspector #194, on an identified date, PSW #132 indicated being the staff who provided care to resident #022's on the identified date. PSW #132 indicated that resident #022 did not express pain when care was being provided. Resident #022 was being assisted with transfer when they expressed pain. PSW #132 indicated during same interview that resident #022 did not express any further pain until a specified time later. PSW #132 indicated during interview with inspector #194 that resident #022 only expressed pain for a few seconds during the provision of care.

The licensee's internal investigation statements on an identified date, for PSW #133 indicated that resident #022 expressed pain from time to time during the provision of care.

During interview with inspector #194, on an identified date, PSW #133 indicated that resident #022 expressed pain throughout the provision of care. When asked by inspector #194 if resident #022 reacted differently during the provision of care, on the identified date, PSW #133 indicated, that resident #022 stated "specific pain" while being transferred.

PSW #132 and #133 indicated that resident #022 refused to come for the a meal related to pain in a specific area. PSW #132 and #133 indicated that RPN #134 was notified and PSW staff were directed to assist resident #022 to the dining room. PSW #133 indicated during interview with inspector #194 that resident #022 was compliant with being assisted to the dining room and finished their meal without assistance.

The licensee's internal investigation statements on an identified date, indicated that RN #134 observed resident #022 being provided care. RPN #134 was asked if resident #022 was expressing pain at the time of the observation and RPN #134 replied that, no. RPN #134 was not interviewed by inspector #194, as they were not available.

Review of the progress notes and medication administration records for resident #022 on an identified date indicated that, RPN #134 administered pain medication at a specific time. Resident #022's clinical health record does not identify the reason for the pain medication, or that any assessment was completed by RPN #134 prior to administration of the pain medication.

During interview with inspector #194, on an identified date, RN #131 ndicated that they were informed by PSW #132 and #133 prior to a meal on an identified date, that resident #022 was complaining of pain during provision of care and required a change in transfer status. RN #131 indicated that an assessment related to the transfer status was conducted and resident #022 was assessed to be in pain. RN #131 indicated that the resident's transfer status was changed. RN #131 indicated during the interview with inspector #194 that resident #022 had the opportunity to speak to RN #131 without PSW staff present during the assessment process and did not inform RN #131 of the incident during the provision of care.

The licensee's internal investigation into the allegations of staff to resident abuse was

completed and concluded that physical abuse was unfounded but that neglect of resident#022 was founded.

The licensee failed to ensure that resident #022 was protected from neglect by staff on an identified date. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #022's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to Log # 008719-18:

During inspection of a Critical Incident for an allegation of staff to resident abuse resulting in an injury, an increase in pain for resident #022 was noted.

Resident #022 was injured during provision care by PSW staff. Resident #022 was noted to have a decline in mobility and ability to complete ADL's, increased pain to a specific area and required the use of PRN (as needed) medication for pain management.

During interview with inspector #194 on an identified date, the DOC indicated that the Abbey Pain scale (APS) is the formal pain assessment tool in the home. The DOC indicated that the APS would be used by Registered Nursing staff to assess new pain,

change in pain medication and when PRN's were used frequently for increased pain.

Review of resident #022's Electronic Medication Administration Record (eMAR) for a specific period was completed by inspector #194. Resident #022 is noted to have been prescribed specific medications for pain management:

During the an identified period the eMARs indicated that resident #022 was administered pain medications a specified number of times.

During the another identified period the eMARs indicated that resident #022 was administered pain medications a specified number of times.

During interviews with inspector #194 on an identified date RPN's #139, #124 and #143 indicated that being aware of the Pain assessment tool in the home "Abbey Pain Scale" and that a pre and post score was to be recorded in the progress notes after administering a PRN medication. RPN #139, #124 and #143 also confirmed that the RN on duty was to be notified prior to the administration of a PRN medication to residents.

During interview with inspector #194 on an identified date, RN's #141 and #131 indicated that the prevailing practice at the home, was for RPN's to contact the RN by phone prior to administering a PRN medication to residents. Both RN #141 and #131 indicated that during the phone conversation with the RPN, information related to reason for use, such as; effectiveness in the past, determination of new versus chronic pain is discussed prior to authorization of PRN use. Both RN #141 and #131 during interview with inspector #194, indicated that the conversation with RPN was not documented in the resident's clinical health records by the RN.

Review of the progress notes related to PRN use, for resident #022 for an identified period indicated:
- On specific dates, RPN #139 and RPN #134 administered pain medication with no post APS score or location of pain documented.
- On an identified date, RPN #149 administered pain medication with no pre or post APS scores documented.
- On specific dates, RPN #152, RPN #150, RPN #134 ad RPN #124 administered pain medication with no pre or post APS scores or location of pain documented.
- On specific dates, RPN #151 and RPN #139 administered pain medication with no location documented.
- On specific dates, RPN #134, RPN #139 and RPN #153 administered pain medication

with no post APS score documented.

The licensee failed to ensure that when resident #022's pain was not relieved by the initial interventions, the resident was not assessed using the clinically appropriate assessment instrument identified by the home as the Abbey Pain scale on the identified dates. [s. 52. (2)]

2. Related to Log #008719-18:

During inspection of Log #008719-18, non compliance was identified under O. Reg.s. 52(2) related to pain management, the scope of the inspection was increased to include resident #031.

The plan of care for resident #031 indicated that the residents level of assistance related to ADL's was described as requiring full assistance from staff for eating, toileting, transferring and dressing, dependent on staff for the use of mobility device in the home. Resident #031 was noted to be able to answer questions requiring one or two word answer.

Review of the Medication Administration record related to pain management for an identified period for resident #031 was completed and indicated the use of regularly scheduled and PRN pain medications.

Review of the eMARS for an identified period for resident #031 related to PRN use, indicated that on specified dates, pain medication was administered.

Review of the progress notes for resident #031 related to the documentation of the PRN and Abbey pain scale use indicated:

- On an identified date, RPN #155 administered pain medication to resident #031, with no pre or post APS score documented.
- On an identified date, RPN #156 administered pain medication, to resident#031, with no location of pain documented.

The licensee failed to ensure that when resident #031's pain was not relieved by initial interventions, resident #031 was assessed by a clinically appropriate assessment instrument, on two specific dates. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose., to be implemented voluntarily.

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2018_603194_0018
Log No. / No de registre :	001849-18, 004738-18, 004829-18, 006897-18, 008719-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 6, 2018
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
LTC Home / Foyer de SLD :	Fairhaven 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lionel Towns

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Corporation of the City of Peterborough and The Corporation of the County of Peterborough, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The Licensee must be compliant with s.19(1) of the LTCHA.

Specifically the licensee must:

1. The licensee must ensure that residents are protected and not neglected by any staff by developing and implementing a process that documents actions to:

(a) ensure that any emotional or physical change in condition to the resident must be immediately reported to the registered staff and/or nursing managers.

(b) to ensure a comprehensive assessment is to be completed by the registered nurse to ensure that the resident is provided with the treatment, care, services or assistance required for health, safety or well-being.

(c) to ensure that all assessments and interventions provided for the resident are to be documented in the resident's clinical health record.

Grounds / Motifs :

1. 1. Every licensee of a long term care home shall protect residents from abuse by anyone and shall ensure that resident are not neglected by the licensee or staff.

The Definition of Neglect under O. Reg. 79/10 s. 5; Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being or one or more residents.

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The licensee's internal investigation into the allegations of staff to resident abuse

was completed and concluded that physical abuse was unfounded but that neglect of resident#022 was founded.

The licensee failed to ensure that resident #022 was protected from neglect by staff on an identified date. [s. 19. (1)]

The severity of the issue was determined to be a level 3 with actual harm to resident #022. The scope of the issue was a level 1, as it was an isolated incident. The compliance history indicated an order was issued based on the severity of the incident resulting in harm to resident #022. The home had a level 3 history with previous non compliance issued under this section of the LTCHA that included:
- a Compliance Order (CO)#001 issued September 9, 2016 with a compliance date of December 9, 2016, (#2016_291194_0017).
(194)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
Bureau régional de services : Central East Service Area Office