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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2021	2020_815623_0022	016341-20, 016424-20, 016695-20, 017068-20, 018253-20, 021602-20, 022253-20, 023005-20	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): November 23 - 27, 30, and December 1 - 5, December 8 - 11, 2020

During the course of this inspection the following intakes were inspected concurrently:
Critical Incident Reports for falls with injury.
Critical incident Reports for unexpected death.
Critical Incident Reports for allegations of staff to resident abuse.

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

The inspector also reviewed resident health care records, internal investigation documentation, applicable policies, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions. Infection Preventions and Control practices were also observed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 has failed to ensure that the care set out in the plan of care for resident's #005, #007, #008, #009, and #010 related to continence care was provided to them as specified in the plan.

PSW #111, PSW #110 and PSW #118 submitted a written statement to RPN #140 which indicated that on multiple occasions they observed PSW #107 and PSW #108 providing care to resident's #005, #007, #008 and #009 without using the appropriate techniques and placing the residents at risk of a negative outcome. The written statement also indicated that PSW #107 and #108 refused to assist resident #010 when the resident requested to be toileted, and told the resident they would need to wait until the following shift for continence care.

The written plan of care for resident's #005, #007, #008, #009 and #010 related to continence care identified that each resident required assistance from staff.

RN/RCM #102 and #105 indicated that the care plan was clear for resident's #005, #007, #008, #009 and #010 identifying the assistance each resident required for continence care and the plan of care was not followed. The residents were at an increased risk of altered skin integrity by the care not being properly provided. The DOC confirmed the expectation of the home is resident's will receive the assistance required for continence care.

Sources: Resident #005, #007, #008, #009 and #010's care plan, progress notes, internal investigation notes and witness statements from PSW's #111, PSW #110, PSW #112, PSW #114, PSW #116 and PSW #118, interview with RN/RCM #102 and #105 and DOC. [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 or care 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 :

The licensee has failed to ensure that the abuse policy was complied with related to reporting allegations of staff to resident neglect related to personal care.

Review of the licensee's policy Zero Tolerance of Abuse and Neglect directed that It is mandatory that all Fairhaven staff report any act, or allegation of resident abuse to a member of the registered staff or management team as soon as the incident occurs.

On a specified date PSW #111 notified RPN #140 that they needed to report co-workers PSW #107 and PSW #108 for a pattern of behaviours that they felt constituted abuse. PSW #111, PSW #110 and PSW #118 together submitted a written statement alleging multiple instances of resident neglect identifying residents #004, #005, #006, #007, #008, #009, #010 and #011 as recipients on multiple occasions over a period of approximately one week. This information was not reported to the RN on duty immediately at the time of each incident. A Critical Incident Report was submitted to the Director once Management became aware of the allegations.

Review of the licensee's internal investigation revealed that PSW #112, #114 and #116 had also witnessed on more than one occasion PSW #107 and #108 acting in a way that constituted suspected resident abuse and did not immediately report at the time of the incidents.

During separate interview's RN/RCM #102, RN/RCM #105 and the DOC confirmed that the expectation of the home is that all alleged, suspected or witnessed abuse is immediately reported to a registered staff or Management and that the policy was not followed.

Sources: CIR, Zero Tolerance of Abuse policy March 2020, licensee's internal investigation, Interview's with RN/RCM #105 and the DOC. [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 by ensuring that there is a written policy to promote zero tolerance of abuse and neglect of residents, and by ensuring that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that resident #010 who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

PSW #111, PSW #110 and PSW #118 submitted a written statement to RPN #140 that indicated PSW #107 and PSW #108 had been overheard on multiple occasions, to tell a resident that assistance would not be provided when the resident asked to be toileted. The allegation also stated that when the resident requested to be assisted with continence care later in the shift, the PSW's would tell the resident that they would have to wait for the next shift.

Review of the licensee's internal investigation revealed that the SDM for the resident confirmed that on multiple occasions the resident had told their SDM that the PSW staff had refused to assist them. The SDM indicated that the resident would not report this to the Fairhaven staff for fear of reprisal. During an interview with the resident they confirmed the allegations also.

Review of the written plan of care identified that the resident required one-person to assist with all aspects of continence care.

An interview with RN/RCM #102 and #105 confirmed that the resident was able to vocalize their need for assistance and that they required one person to assist with continence care. The RN/RCM indicated that the assistance was not provided to the resident in order for them to manage and maintain continence. This placed the resident at an increased risk of altered skin integrity.

Sources: Resident care plan and progress notes, internal investigation notes and witness statements from PSW's #111, PSW #110, PSW #112, PSW #114, PSW#116 and PSW #118, interview with RN/RCM #102 and RN/RCM #105. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's #004, #005, #008 and #0009 were given sufficient time to eat at their own pace.

PSW #111, PSW #110 and PSW #118 submitted a written statement to RPN #140 which indicated that on multiple occasions they observed PSW #107 and PSW #108 removing food from in front of resident's #004, #005, #008 and #009, before they had finished eating. These residents were slow eaters and/or required assistance and encouragement to eat. The PSW staff reported that when given the appropriate time, these residents will usually consume 95% of their meal.

Review of the written care plan for resident's #004, #005, #008 and #009 indicated that resident's #004, #008 and #009 require total assistance to eat and are to be fed slowly. Resident #005 required supervision with minimal assistance,but if the resident becomes fatigued one staff is to assist the resident to eat. Weight records were reviewed for each resident and there was no weight loss identified.

Review of the licensee's internal investigation indicated that during an interview with RN/RCC #105 and Program & Support Services Manager #109, resident #005 stated that PSW #107 and #108 had removed food from in front of them before they had even started to eat. Resident #009 stated that PSW #107 and #108 does provide assistance to eat but they do not feed them all of their food before taking it away. Witness statements from PSW #112, #114 and #116 also supported that resident's #004, #005, #008 and #009 were having their food removed by PSW #107 and #108, before they had finished eating, on multiple occasions.

RN/RCC #102 and #105 indicated that the care plans for resident's #004, #005, #008 and #009 were very specific detailing the requirements of each resident for optimal nutritional intake. The actions of PSW #107 and #108 place the residents at risk of reduced nutritional intake and potential weight loss.

Sources: Resident #004, #005, #008 and #009's care plan, progress notes, internal investigation notes and witness statements from PSW's #111, PSW #110, PSW #112, PSW #114, PSW#116 and PSW #118, interview with RN/RCM #102 and RN/RCM #105. [s. 73. (1) 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 home has a dining and snack service that includes at a minimum, sufficient time for every resident to eat at his own pace, to be implemented voluntarily.

Issued on this 11th day of January, 2021

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

Original report signed by the inspector.