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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2013	2013_105130_0016	H-001221-12	Complaint

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

Long-Term Care Home/Foyer de soins de longue durée

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 2013

PLEASE NOTE: This inspection was conducted simultaneously with the following inspections: H-001221-12, H-000100-13 and H-000140-13

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Staff, personal support workers, dietary staff and residents.

During the course of the inspection, the inspector(s) Interviewed staff and residents, reviewed relevant clinical records and policies and procedures and observed care related to H-002247-12.

Ad-hoc notes were used during this inspection.

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's care plan and had convenient and immediate access to it.

a) Resident #003 was admitted to the home in 2013, staff confirmed that the initial care plan was not printed and available to front line staff providing care within the required time frame.

b) According to the plan of care, Resident #002 required one bedrail up at all times when in bed for safety. In 2013, the resident sustained a fall, as a result of bedrail being raised. The narrative care plan in the computer was revised after the fall and indicated: no bedrail use as it posed a potential risk to the resident. The narrative care plan found in the care plan binder after the care plan revision date and still directed staff to put one bedrail up for safety. Two staff interviewed in 2013, stated the resident required one bedrail up. [s. 24. (7)]

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. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the falls prevention and management program was implemented.

1.) The Falls Prevention and Post Fall Management Program Policy No: 9-1 indicated the following: "The fall event will be communicated and documented on all shifts for 72 hours post fall." Staff interviewed confirmed the fall event should be communicated and documented in progress notes, but were not consistently done so for the following residents with recorded falls on specific dates.

a) Residents #001, 002 and 003 sustained a number of identified falls in 2013.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse, by anyone.

a) In 2012, Resident #001, who was to be constantly supervised for a history of posing a risk to residents, was left unsupervised for a specified time frame. During this time the resident approached Resident #006 and touched the resident in a sexual manner. This information was confirmed by the critical incident reported and staff interviewed. [s. 3. (1) 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 to ensure that every resident is protected from abuse by anyone, to be implemented voluntarily.

WN #4: 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 did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) The plan of care for Resident #001 indicated the resident had a history of inappropriate behaviour; required constant support at specified times, seven days in one week; staff to ensure that at no time resident can physically reach other co-residents. In 2012, Resident #001 approached Resident #006 touched the resident in a sexual manner. The clinical records reviewed and staff interviewed confirmed the resident was not constantly supervised as per the plan, at the time the incident occurred.

b) According to the plan of care for Resident #001, staff were to ensure the bathroom door was closed and the door stopper was down, before leaving the resident unattended, as they were high risk for falls and would attempt to self transfer onto toilet. In 2012, the resident was found on the floor in the bathroom, after attempting to self transfer to toilet. The clinical record verified the door was left open and unlocked. In 2013, the resident's power of attorney (POA) entered the resident's room and found the resident enroute to the bathroom as the bathroom door was again open and unlocked. [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 care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #5: 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 did not ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

1.) The home's policy: Non-Abuse of Residents 2-60 indicated: Procedure and Investigation: 2. Immediately assess the resident for physical harm or emotional distress, 6. The resident's substitute decision-maker will be made aware immediately of an alleged, suspected or witnessed incident of abuse, Resident Advisor or Delegate: 1. The resident who has been a victim of abuse will be visited by the Resident Advisor or delegate on the next business day.

a) In 2012, Resident #006 was inappropriately touched by a co-resident. There was no documentation in the clinical record that the resident was assessed post incident.
b) The resident's power of attorney (POA) was unavailable at the time of the incident, but had provided the home with an emergency contact during their absence. According to the clinical record and staff, the emergency contact person was not informed of the incident. The POA was not made aware of the incident until some time later.
c) The Resident Advisor/Delegate did not visit the resident as required by policy.

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 policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

a) In 2013, at a specific date and time, the door to the Birch Terrace treatment room, containing medications, preparations and substances, was observed to be propped open and unsupervised. Staff confirmed the door should be closed and locked at all times. [s. 130. 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 steps are taken to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 20th day of August, 2013

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

Gillian Tracey

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

Ministére 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2013_105130_0016
Log No. / Registre no:	H-001221-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2013
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KAREN POW

To ST. PETER'S CARE CENTRES, 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

Ministére 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 :

O.Reg 79/10, s. 24. (7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

Order / Ordre :

The licensee shall ensure that staff and others who provided direct care to a resident, including Residents #002 and #003, are kept aware of the contents of the resident's care plan and have convenient and immediate access to it.

Grounds / Motifs :

1. According to the plan of care, Resident #002 required one bedrail up at all times when in bed for safety. In 2013, the resident sustained a fall, as a result of the bedrail being raised. The narrative care plan in the computer was revised on a specific date in 2013 and indicated: no bedrail use as it poses a risk to the resident. The narrative care plan found in the care plan binder on a later date in 2013, still directed staff to put one bedrail up for safety. Two staff interviewed after the incident in 2013, stated the resident required one bedrail up. (130)

2. Resident #003 was admitted to the in 2013, staff confirmed that the initial care plan was not printed and available to front line staff providing care. (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2013

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall ensure that the Falls Prevention and Post Fall Management Program Policy, including No: 9-1, is implemented.

Grounds / Motifs :

1. The licensee did not ensure that the falls prevention and management program was implemented. The Falls Prevention and Post Fall Management Program Policy No: 9-1 indicated the following: "The fall event will be communicated and documented on all shifts for 72 hours post fall." Staff interviewed confirmed the fall event should be communicated and documented in progress notes, but were not done so, in accordance with the home's policy, for Residents #001, 002 and 003, who sustained a number of falls on identified dates.

(130)

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

Ministére 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of July, 2013

Signature of Inspector / Signature de l'inspecteur : Gillian Tracey

Name of Inspector / Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office / Bureau régional de services : Hamilton Service Area Office