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
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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
Nov 13, 2014	2014_365194_0023	O-001260-14	Complaint

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

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 Complaint inspection.

This inspection was conducted on the following date(s): November 10 & 12, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Unit Manager, Personal Support Worker (PSW), Resident

During the course of the inspection, the inspector(s) Observed staff/resident provision of care, toured the identified unit, reviewed clinical health records and Infection Control Minutes

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

POA for Resident #01 informed MOHLTC that on identified day, a dirty diaper was found in the resident's room on the chair.

Staff #104 explained to the Unit Manager that she was walking in the hall when she was asked by the family member of Resident #01 to come into the room. Staff #104 stated to Unit Manager that there was a soiled brief on the chair, she removed the brief and apologized to the family member and left the room.

During an interview PSW #107 indicated that a co resident had been found in Resident #01's room on the identified day. PSW #107 returned Resident#02 to the resident's room , where the staff noticed the resident's incontinent brief was missing. When asked, PSW #107 stated that she did not look for the missing brief. PSW #107 stated that it was almost meal time and she was very busy. PSW #107 stated that co resident was wearing a white brief and Resident #01 does not.

Both staff involved in the incident failed to participate in the implementation of the infection control program, when the missing brief was not located and disposed of properly and when the chair where the family member found the soiled diaper was not disinfected by staff who removed the diaper. [s. 229. (4)]

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 ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 13th day of November, 2014

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