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

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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
Feb 19, 2015	2015_292553_0002	O-001384-14	Follow up

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

MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 3,4,5,6,10,11, 2015

During the Follow up inspection, Log # O-001444-14 was also inspected upon.

During the course of the inspection, the inspector(s) spoke with The CEO, Director of Care (DOC), Unit Managers (UM), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Residents, Family Members, and Personal Support Workers (PSW). In addition to speaking to the above mentioned people, health care records related to specified Residents were reviewed, Staff and Resident interactions were observed, Resident to Resident interactions were observed and relevant policies were reviewed when deemed appropriate.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2014_365194_0022	553

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

When reviewing Critical Incident Reports after the compliance date of November 28, 2014, the following was discovered by Inspector #553:

A critical incident report (CIR) occurred on a specified date. The CIR was as follows:

Resident #22 was lying in bed due to having pain, Resident #23 wandered into Resident #22's room. Resident #23 started to look at everything in the room, Resident #22 was getting upset with this and asked Resident #23 to leave. Resident #23 went into the washroom, Resident #22 went into the washroom as well and reportedly struck Resident #23 with a hairbrush leaving small pin-point marks on Resident #23's hand. This event was not witnessed, what was witnessed by a HCA was that Resident #22 had a hairbrush in hand and that Resident #23's hand was red and showing signs of being struck. Resident #22 denied striking Resident #23. Family was notified of this incident, the Physician and Police were notified as well on a specified date.

The Director was first made aware of this incident on a specified date when the CIR was

submitted by the Licensee.

Interview conducted by Inspector #553 with UM #108 on February 4, 2015 regarding the CIR.

-The Critical Incident was not witnessed.
-Resident #23 had fairly clear marks on the back of the hand which indicated the Resident had been struck with the hairbrush that Resident #22 was holding.
-The Critical Incident happened on a specified date, the investigation into this incident commenced immediately on that specified date.
-UM #108 had recently been given instructions by the new CEO, that the CEO requests to preview the CIRs prior to submitting to ensure the wording is correct. However, UM #108 stated that the CEO was unable to access the CIR system on a specified date and sent an email stating this and to just submit the CIR. UM #108 did not receive this email until the next morning, indicating why the delay in reporting occurred.

Interview conducted by Inspector #553 with CEO on February 6, 2015 related to the submitted critical incident.

The CEO's previous place of employment had a procedure in place where the Administrator would review a CIR prior to submission to ensure accuracy and an appropriate amount of information be provided. To address this concern currently, the CEO indicated to the management team that CIRs that were to be submitted had to be pre-approved by the CEO for sufficient content. Regarding the specific critical incident, the CEO indicated that the CI was submitted late related to legislative requirements due to the process. The CEO indicated that this was no longer going to be the practice as they have confidence in the management team in submitting timely and appropriate CIRs. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #21's written plan of care set out the planned care for Resident #21 related to the usage of a locomotive aide.

Review of Resident #21's plan of care related to mobility and transferring (last revision made on a specified date).

Resident #21 requires set up help only, and is independent in transfers with the use of a mobility aide.

Resident #21 was observed to be in a wheelchair during the course of the inspection; while eating lunch, partaking in exercises, watching TV and spending time in the bedroom.

Resident #21's plan of care has no indication of the use of a locomotive aide.

Interviews were conducted with staff members during the course of the inspection. The following was indicated to Inspector #553:

PSW #103 stated:
Resident #21 will use either a locomotive aide or a mobility aide. This is dependent upon how Resident #21 is feeling. If Resident #21 is reporting pain, Resident #21 will often then use the locomotive aide.

PT #110 indicated the following related to Resident #21:
-Resident #21 used to be independent walking with mobility aide, now often complain of pain.
-Resident #21 is being walked with Physio and with other staff as well.
-When Resident #21 has pain, the locomotive aide is used.

RPN #111 stated the following:

-Currently Resident #21 will walk small distances within home with 1 x assistance. These distances will include going to the washroom and around Resident #21's room.
-Resident #21 will use the locomotive aide for long distances.
-RPN #111 stated that this change with Resident #21 using a locomotive aide had started at least 3 months ago. Resident #21 started complaining of pain, which gave Resident #21 problems gripping the mobility aide.
-RPN #111 stated that this information would be found within Resident #21's care plan.

Unit Manager #108 stated:
-Resident #21 will use a locomotive aide when the Resident complains of pain.
-Resident #21 will complain of soreness, but still be able to walk with 1 x assistance.

Inspector #553 reviewed Resident #21's progress notes to identify when a locomotive aide for Resident #21 was first implemented. The progress notes indicated that Resident #21 has been using a locomotive aide intermittently related to discomfort for approximately 5 months.

Inspector #553 reviewed Resident #21's physiotherapy assessment completed on a specified date. In the assessment there was no mention of use of a locomotive aide, Resident #21 was assessed as being able to walk with a mobility aide with 1 staff

assistance for distances that range from 100-150 feet.

During an interview on February 4, 2015 with Unit Manager #108, Inspector #553 indicated that there was no mention of the use of a locomotive aide for Resident #21 in the Resident's plan of care. As of February 6, 2015 the use of a locomotive aide on an as needed basis was included in Resident #21's plan of care. [s. 6. (1) (a)]

Issued on this 20th day of February, 2015

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

Original report signed by the inspector.