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
Apr 17, 2015	2015_360111_0004	O-001371-14	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

LYNDA BROWN (111)

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): February 9-11, 2015

During this inspection, non-compliance was identified for an incident that occurred prior to the coming into force of the LTCHA, 2007, and was identified in The Long-Term Care Program Manual (under WN #2 & #3 on page 1 & 2). Additional non-compliance was identified for a different resident under the current Ontario Regulation 79/10, as identified under WN#1 on page 4).

The licensee was found to be in non-compliance with The Long-Term Care Homes Program Manual Standards and Criteria (Criteria A1.11 (1) & M3.7). These findings of un-met standards and criteria was identified in the review of a staff to resident physical abuse incident that occurred prior to the coming into force of the LTCHA, 2007 & Ontario Regulations, 79/10.

WN #2: The Licensee failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria as identified under Unmet Criteria A1.11 which stated: Resident's rights which shall be fully respected and promoted include, but are not limited to the following rights contained in the Long Term Care Statute Law Amendment Act, 1993 (Bill 101),
(1)Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's dignity and individuality and to be free from mental and physical abuse.

Findings:
Review of the homes investigation and the critical incident report indicated Resident #2 no longer resides in the home. On a specified date and time, Staff #1 witnessed a staff to resident physical abuse incident from Staff #2 towards Resident #2. Staff #1 reported the incident 4 days later. Staff #2 received disciplinary action as a result and no longer works in the home.
Therefore,the resident's right to be treated with courtesy and respect, and free from physical abuse was not fully respected and promoted.

WN #3: The Licensee failed to comply with The Long-Term Care Homes Program Manual Standards and Criteria under Unmet Criteria M3.7 which stated: Unusual occurrences shall be reported according to Ministry policy.

Findings:
A critical incident report(CIR) was received on a specified date by the Director for a staff to resident physical abuse incident. The CIR indicated the incident occurred on the same date as the report. Review of the homes investigation indicated the incident actually occurred 4 days earlier. The Ministry policy indicated that unusual occurrences involving abuse are to be reported within one day of occurrence and was not reported for 4 days.
This concludes the findings related to The Long-Term Care Home Program Manual.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Unit Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), reviewed resident health records, reviewed staff training records, and reviewed the home's investigations.

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

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the health record for Resident #1 indicated the resident had a physician order for medication patch to be applied in the morning and removed at bedtime.

Review of progress notes, Medication Administration Records and Medication incident reports indicated:
- on a specified date and time, extra medication patches were found on the resident. The resident was assessed and noted to be stable. The nurse removed all the patches and notified the physician. The family was notified of the medication incident and of the physician's response related to the incident.
-There was no indication in the progress notes (during that period of time) to indicate staff were unable to locate the medication patches (that were supposed to be removed).
-on a second specified date and time, an extra medication patch was found on the resident. There was no documentation to indicate (on that date) the medication patch was not located.

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 drugs are administered to resident's in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 21st day of April, 2015

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

Original report signed by the inspector.