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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 28, 2016	2016_270531_0033	027610-16, 028414-16	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's at Fleming
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

SUSAN DONNAN (531)

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): Sept. 21, 22, 23, 26, 27 and 28, 2016.

During the course of the inspection, the inspector(s) spoke with a resident, residents' substitute decision maker, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Unit Area Managers, the Director of Operations, an Officer of the Law and the Administrator.
During the course of the inspection the inspector toured the home, reviewed resident health care records, observed resident care and services and reviewed appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 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 the plan of care set out clear direction to staff who provided direct care to resident #012 pertaining to the preferred method of shaving.

In reference to log #027610-16

On an identified date a Critical Incident Report was submitted to the Ministry of Health and Long-Term Care which indicated that resident #012 was shaved improperly.

A review of resident #012's plan of care indicated the following:
Personal Hygiene: Use resident's electric razor to shave the resident. Do Not use a disposable razor at anytime when shaving the resident.

On Sept 27, 2016 during an interview with resident #012's spouse he/she indicated that he/she specifically asked the nurse in charge to ensure that resident #012 be shaved using an electric razor because of sensitive skin. The spouse indicated that on a specified date resident #012 was shaved with a disposable razor.

The Unit Area Manager (UAM) indicated that on a specified date the nurse updated the written plan of care to indicate that the resident be shaved with an electric razor only but did not update the kardex or communication book; therefore the staff who provided direct care to resident #012 were not given clear direction for shaving the resident. She indicated that measures have been implemented to ensure that direct care staff are kept aware of the contents of the plan of care. [s. 6. (1) (c)]

Issued on this 28th day of October, 2016

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

Original report signed by the inspector.