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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 25, 2017	2016_272641_0017	033217-16	Complaint

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

CATHI KERR (641)

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 29, 30, December 1, 2, 5, 6, 7, 13, 14, 19, 20, 2016

During this inspection the following were inspected: Log #033217-16, a complaint related to resident care; Log #033223-16, a complaint related to the plan of care; and Log #029291-16, a complaint related to falls management and resident care.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), Home Area Managers (HAM), the Nurse Practitioner, Physiotherapist (PT), Physiotherapist assistant (PTA), Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Care Workers, Maintenance Worker, residents, and resident's family members.
As well, the Inspector observed resident care, interactions between staff and residents, reviewed resident heath care records, the licensee's investigation documentation, and the licensee's policies related to complaints and falls.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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 had failed to ensure that the care set out in the plan of care for resident #002, was provided to the resident as specified in the plan.

A telephone complaint was received by the Home Area Manager (HAM) #116 on a specified date, related to resident #002's basic care not being met on a consistent basis. A further complaint of the same nature was received via an email to the Chief Executive Officer (CEO) and Director of Care (DOC) two weeks later. The complainant also sent emails to the CEO and DOC on two more dates, identifying four more days that the resident did not have basic care needs met.

During a telephone interview on December 7, 2016 at 1450 hours, the complainant indicated to Inspector #641 that she had ongoing issues with the staff not completing resident #002's morning care. The complainant feels these basic requirements should be done routinely every morning.

A review of resident #002's current care plan indicated the staff were to complete specific care needs for resident #002 in the morning and in the evening.

During an interview on December 13, 2016 at approximately 1340 hours with Inspectors #641 and #601, PSW #123 indicated that she works full time on the resident's unit. Resident #002 requires total care, including for morning care.

During an interview on December 13, 2016 at approximately 1500 hours with Inspectors #601 and #641, HAM #116 indicated that she was aware that a PSW had not completed resident #002's morning care on the morning prior. In an email sent to the complainant from the CEO on a specified date, he acknowledged that the morning care was not completed.

The licensee had failed to ensure that the care set out in the plan of care for resident #002, specifically relating to the morning care, was provided to the resident as specified in the plan. (Log #033217-16) [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001, as specified in the plan.

On a specified date, the licensee received a complaint through email related to resident #001. The email, indicated that on a specified date, resident #001 was observed to be sitting alone on the toilet. There was a reference made in the email of posted signage in the resident's room indicating that the resident was not to be left unattended on the toilet. The complaint also indicated, that the staff had not been consistently charting the resident's bowel movements on the chart provided in the resident's bathroom.

During a telephone interview with the complainant at 1330 hours on December 12, 2016 with Inspector #641, the complainant indicated that when he arrived to visit resident #001 on the specified date, the resident was sitting alone on the toilet. He indicated that it was 2-3 minutes before two of the staff came and attended to the resident. He mentioned that resident #001's care clearly indicated that the resident must have someone in attendance at all times when on the toilet.
The complainant also indicated that he was concerned about resident #001's bowel movements and that the home had established that the staff would document this on a chart in the resident's bathroom. He indicated that this was not being done consistently and there were often gaps of 3-4 days without documentation.

A review of resident #001's current care plan by Inspector #641, indicated that the resident was not to be left unattended when on the toilet. This intervention was created three years prior to the incident and had not been changed since that date. During an observation of the resident's room by the inspector on December 13, 2016, a pictogram was noted above the resident's head board that indicated that the resident was not to be left unattended on the toilet.

During an interview with PSW #118 and PSW #103 on December 14, 2016, they indicated to Inspectors #641 and #601 that they had left resident #001 on the toilet to attend another resident. PSW #118 indicated that when they returned to the room a few minutes later, resident #001 had a visitor waiting in the hall.

A further review of the resident's current care plan indicated that the staff were to ensure to document each of the resident's bowel movements on the sheet provided in the resident's bathroom. This intervention was created six months prior to the incident and had not been altered since that date.

Inspector #641 observed on December 13, 2016, a notice in the resident's bathroom, above the toilet indicating that the staff were to document the resident's bowel movements on a clipboard in the resident's bathroom. The clipboard had documentation of the resident's bowel movements on 15 specified days. A review of the resident's electronic charting indicated that the resident had bowel movements documented on 19 specified days. The paper record in the resident's bathroom had documentation that was not on the electronic charting and the electronic charting had documentation that was not on the paper chart in the resident's bathroom.

During an interview with PSW #103 on December 14, 2016 at approximately 1240 hours, she indicated that the staff were required to document resident #001's bowel movements but she did not think that resident #001's care plan directed staff to document resident #001's bowel movements on the sheet in resident #001's bathroom.

During an interview on December 13, 2016 at approximately 1504 hours Home Area Manager #116 indicated to Inspectors #641 and #601 that staff hadn't been as diligent documenting on the sheet in the resident's bathroom but they had been documenting the resident's bowel movements electronically at Point of Care.

The licensee had failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan of care. (Log #033223-16) [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care related to resident #003's nutritional interventions for a medical condition and bowel management was provided to the resident as specified in the plan.

Record review of resident #003's clinical health records by Inspector #601 identified that resident #003 was admitted to the home three years prior with medical issues concerning nutritional intake and constipation.

During a telephone interview on December 9, 2016, the complainant indicated to Inspector #601 that resident #003 was on a specified diet due to a medical condition and that two or three months ago resident #003 had received an item of food that wasn't on that diet. The complainant indicated that resident #003 complained of a sore throat following eating the specified item. The complainant also indicated to Inspector #601 that staff do not follow resident #003's plan of care regarding diet.

Inspector #601 reviewed resident #003's progress notes on December 14, 2016 and identified that on a specified date, RPN #115 documented that resident #003 was given a an item of food not on the specified diet by a PSW at the supper meal. Review of the documentation by Inspector #601 identified that resident #003 had taken a bite of the specified item before it was removed from the table. According to the same progress note, resident #003 was able to drink a glass of water without difficulty prior to starting to cough.

On December 14, 2016, Inspector #601 reviewed resident #003's current care plan

interventions and identified that over three years prior, resident #003's intervention was initiated to provide a specific diet due a medical condition.

During an interview on December 20, 2016, PSW #111 indicated to Inspectors #601 and #641 that on a specified date, resident #003 was being monitored by the nurse due to the resident eating an item of food that wasn't on the specified diet at supper. PSW #111 indicated to Inspectors #601 and #641 that resident #003 was coughing and the nurse had given the resident sips of water until the resident stopped coughing. During the same interview, PSW #111 indicated that resident #003 had been on this specific diet for a long time and didn't know how resident #003 received the item.

On a specified date, resident #003 was not provided a specified diet as set out in the plan of care.

2. During a telephone interview on December 9, 2016, the complainant indicated to Inspector #601 that resident #003 had digestive issues. During the same interview, the complainant indicated that because of this, resident #003's bowel movements needed to be monitored to avoid bowel complications. The complainant also indicated to Inspector #601 that staff do not follow resident #003’s plan of care regarding fluids.

On December 14, 2016, Inspector #601 reviewed resident #003’s current care plan related to constipation and the intervention was to provide prune juice at breakfast and to hold the prune juice when resident #003 was having loose bowel movements.

On December 14, 2016, Inspector #601 reviewed resident #003’s documented record for bowel movements in Point of Care (POC) for a specified three month period and identified that resident #003's recorded bowel movement consistency was often loose and watery. Inspector #601 identified that resident #003 had a normal formed bowel movement on September 8, 23 and December 12, 2016.

On December 14, 2016, Inspector #601 observed resident #003 at the breakfast meal service with a glass of prune juice on the table in front of the resident. On December 14, 2016 at approximately 0905 hours, Inspector #601 observed PSW #100 encourage resident #003 to drink the prune juice and told the resident that it would help with the bowel issues. PSW #100 was observed by Inspector #601 assisting resident #003 to drink approximately half a glass of prune juice.

During an interview on December 14, 2016, PSW’s #100, #103 and #111 indicated to

Inspector #601 and #641 that resident #003 was provided prune juice at breakfast daily. PSW's #100, #103 and #111 indicated to Inspector #601 and #641 that resident #003's stool consistency had been loose or watery for over a year and the prune juice was being given to manage the resident's constipation.

During an interview on December 14, 2016, RPN #105 indicated to Inspector #601 and #641 that resident #003 was on bowel medications to manage constipation. During the same interview, RPN #105 indicated that resident #003's bowel pattern was monitored weekly by the RPN's and resident #003's bowel movements were consistently loose and watery.

During an interview on December 14, 2016, the Registered Dietitian indicated to Inspectors #601 and #641 that resident #003 was not to receive prune juice when the resident was having loose bowel movements. (601)(Log #029291-16) [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: 1. care is provided to resident #001 as specified in the plan of care related to the resident not being left unattended on the toilet and having bowel movements documented on the chart in the resident's bathroom;
2. care is provided to resident #002 as specified in the plan of care related to the resident having personal care items in place,
3. care is provided to resident #003 as specified in the plan of care related to the resident's nutritional interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, was acknowledged to the complainant within 10 business days of the receipt of the complaint, indicating what the licensee had done to resolve the complaint.

On a specified date, the licensee received a verbal complaint related to resident #002's basic care needs not being met on a consistent basis. The Home Area Manager #116 forwarded this complaint to the CEO two days later and also documented it in the home's complaints log on that same day. The complainant submitted an email nine days after the initial complaint to the CEO and DOC which spoke in part, to the complaints she had previously addressed. A second email was sent by the complainant four days later, to both the CEO and the DOC, which addressed that a specific item of the resident was not in place that morning. This email was acknowledged by the CEO, indicating that the home would look into the matter. The next email from the complainant was 17 days after the initial complaint, indicating that resident #002's specified personal care items were not available to the resident three days that week that she was aware of. This email also addressed that her original formal complaint had not been addressed within ten business days. This email was responded to by the CEO 14 business days after the original complaint was made, with an action plan addressing the basic care issues that were identified.

During an interview with the complainant on December 7, 2016 at1450 hours with Inspector #641, the complainant indicated that her original complaint relating to resident #002's personal care items not being available to the resident every morning, was a phone call she made to the HAM #116 on a specified date. She indicated that she also

mentioned her complaints again in an email she had sent to the CEO and DOC, related to another issue, nine days later.

During an interview on December 13, 2016 at approximately 1500 hours with Inspector #601 and #641, HAM #116 indicated that she had not sent an action plan to the complainant. HAM #116 indicated that the CEO would have been the one who responded to the complainant and sent her the action plan. After further discussion with HAM #116 and review of email documentation, it was identified that the action plan was sent to the complainant 14 days after the initial complaint was made, via an email from the CEO. The CEO acknowledged that he had been communicating with the complainant regarding her concerns and on December 7, 2016, supplied the inspector with the documentation of all his interactions with her.

The licensee had failed to ensure that the verbal complaint made to the home concerning the care of resident #002, was acknowledged to the complainant within 10 business days of the receipt of the complaint, indicating what the licensee had done to resolve the complaint. (Log #033217-16) [s. 101. (1) 1.]

2. The licensee had failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, was acknowledged to the complainant within 10 business days of the receipt of the complaint, indicating what the licensee had done to resolve the complaint.

On a specified date, a complaint was submitted to the home via email, to the Chief Executive Officer (CEO) and the Director of Care (DOC). In the email, the complainant indicated that seven days prior, resident #001 was observed sitting alone on the toilet, with no staff in attendance. The email made reference of posted signage in the resident's room indicating that the resident was not to be left unattended on the toilet. The complainant also indicated, that the staff had not been consistently charting the resident's bowel movements on the chart provided in the resident's bathroom.

During a telephone interview with the complainant at 1330 hours on December 12, 2016 with Inspector #641, the complainant outlined his concerns related to resident #001 being left unattended on the toilet and that the resident's bowel movements were not consistently being documented on the chart in the resident's bathroom that the home had initiated. The complainant indicated that he had initiated the complaint on a specified date and he hadn't received a response back indicating what the outcome of the home's investigation was until 25 business days later.

After reviewing the complaint documentation provided to Inspector #641 by the CEO and Home Area Manager (HAM), the Inspector noted that the above complaint was entered into the home's complaint's log on the specified date. The DOC responded via email to the complainant on the next day, advising him that he would be notified within 10 days of the outcome of the investigation. The complainant sent an email addressed to the Home Area Manager (HAM) #116, 25 days later (or 19 business days) requesting information related to her investigation, as he had not received any response at that time. The complainant sent a further email ten days later to the CEO, restating his complaints and indicating that he had still not received any information related to the outcome of the investigation. The CEO responded to the complainant via email with the outcome of the investigation, 25 business days after the complaint was made.

The licensee had failed to ensure that the written complaint made to the home concerning the care of resident #001 was acknowledged to the complainant within 10 business days of the receipt of the complaint, indicating what the licensee had done to resolve the complaint. (Log #033223-16) [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, is acknowledged to the complainant within 10 business days of the receipt of the complaint, indicating what the licensee has done to resolve the complaint, to be implemented voluntarily.

Issued on this 30th day of January, 2017

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

Original report signed by the inspector.