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
Jun 7, 2017	2017_599166_0013	005948-17	Resident Quality Inspection

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

CAROLINE TOMPKINS (166), BAIYE OROCK (624), CATHI KERR (641), CRISTINA MONTOYA (461), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 15, 16, 17, 18, 19, May 23, 24, 25, 26, 2017

Log #s, 005282-17, follow up to a compliance order related medications, 004097-17, follow up to a compliance order related to duty to protect, 006989-17, 009137-17 related to allegations of resident to resident physical abuse and Log # s 006433-17, 001018-17 related to resident care were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Residents' Council, President of the Family Council, Clinical Instructor, Nurse Practitioner, Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Receptionist, Physiotherapy Assistant(PTA), Behaviourial Support Ontario(BSO), Housekeeping staff, Dietary Aide, Dietary Manager, Registered Dietitian(RD), Unit Managers(UM), Manager of Quality and Education, Director of Operations, Director of Resident Care, Supervisor of Resident Programs and Services and the CEO.
During the course of this inspection the inspectors, toured resident home and common areas, observed resident to resident interactions, staff to resident interactions during the provision of care, observed snack and a meal service, medication administration, infection control practices, resident programs and activities.
The inspectors reviewed clinical health records, the licensee's investigation documentation and reviewed the licensee's policies and information related to staff education, zero tolerance of abuse and neglect, mandatory reporting, medication administration and infection control.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **3 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
O.Reg 79/10 s. 135. (2)	CO #001	2017_589641_0004	641
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_389601_0033	570

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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the personal care items of residents were labelled.

During the initial tour of the home on May 15, 2017, Inspector #624 observed the following number of unlabelled hair brushes with hair in them and stored in drawers labeled as "hair items." in the respective Spa rooms

Hilltop Home Area
One of four hair brushes unlabeled
Three of three hair brushes unlabeled

Woodland Home Area
Three of four hair brushes unlabeled
Two of two hair brushes unlabeled

Pathway Home Area
Three of four hair brushes unlabeled
Four of six unlabeled

During an interview conducted by Inspector #624 with PSW #102 and RPN #103 (of Hilltop Home Area), RPN #104 (of Woodland Home Area) and RPN #105 (of Pathway Home Area) all four staff members indicated that the home's expectation is that all resident personal care items should be labeled at all times.

In an interview of Unit Manager #101 by Inspector #624 indicated that the home's expectation is that all residents' personal care items should be labeled especially when they are in common care areas like the Spa rooms. [s. 37. (1) (a)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items, i.e. hairbrushes /combs, to be implemented voluntarily.

WN #2: 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 the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

Related to Log #006989-17:

Under O. Reg. 79/10, s.2(1)(b) "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report(CIR) was submitted to the Director for an alleged resident to resident sexual abuse

The CIR indicated, on a specified date, resident #048 was noted to be standing in front of resident #049 touching/groping resident #049's inappropriately.

Review of the licensee's investigation and review of the health records of residents #048 and #049 indicated PSW #125 reported the incident to RPN #122 who intervened and reported the incident to RN #120.

During an interview, the unit manager RN #116 indicated, to inspector #166, that RN #120 was aware of the incident but did not look at the situation as sexual abuse and did not immediately report the incident to the Director and the on call manager was not notified of the incident. The incident was reported to the Director the following day when unit manager RN #116 was made aware of the incident. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and techniques when assisting residents.

Related to Log #006433-17

A Critical Incident Report (CIR) was submitted to the Director, reporting a complaint from resident #044's Substitute Decision Maker(SDM) in relation to continent product use and bruising of skin .

Review of resident #044's plan of care directs staff to use a mechanical lift with 2 staff assist when transferring the resident.

Review of clinical documentation, the licensee's investigation into resident # 044's SDM's complaint related to bruising of the resident and interview with RN #100, indicated, on a specified date, PSW #101 used the mechanical lift unassisted, contrary to the home's policies and the resident's plan of care.

The unit manager also indicated that interviews with all staff working that shift indicated that none of the staff assisted PSW #100 when resident #044 was transferred.

PSW #101 was re-educated on the licensee's policies related to Safe Work practice, Lifts and Transfers, and Safety Violations. [s. 36.]

Issued on this 7th day of June, 2017

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

Original report signed by the inspector.