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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_643111_0012	007092-19	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

LYNDA BROWN (111)

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): April 11, 2019

A critical incident report (CIR) was inspected related to a medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Home Area Manager (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW) and a resident.

During the course of the inspection, the inspector: reviewed the health care record of a resident, observed a resident and reviewed the following home's policies: Suicide -Assessment and Care of the Resident at Risk and Medical Assistance in Dying (MAID).

The following Inspection Protocols were used during this inspection:
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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 :

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A critical incident report (CIR) was submitted to the Director for a medication incident/adverse drug reaction that occurred on a specified date. The CIR indicated RPN #100 went to resident #001's room at a specified time and found the resident with a significant change in condition. RN #101 also responded to resident #001's room and the staff determined the resident had a significant change in condition and was transferred to hospital for an assessment.

Review of the health record for resident #001 indicated the resident had specified diagnoses. The electronic Medication Administration Record (eMAR) for a specified month, indicated the resident received specified medications and was on a daily specified intervention at various times each day.

Review of the current written care plan for resident #001, indicated the resident demonstrated a specified responsive behaviour and had specified interventions. The care plan was updated on a specified date, after the incident occurred and additional interventions were identified.

Review of the progress notes for resident #001, over a specified dates indicated the resident had a history of a specified responsive behaviour with specified interventions implemented. On a specified date and time, the SDM had expressed concerns related to a specified behaviour and requested nursing staff complete a specified intervention.The SDMs specified intervention was not implemented until the following day and only partially implemented. The following day at a specified time, RN #106 spoke to the resident's SDM regarding the residents' specified responsive behaviour that occurred a few days prior and indicated they would request the resident be referred to a specialized resource The RN also informed the resident and the Nurse Practitioner (NP) of the referral. A specified intervention was also implemented in the residents room and a risk was identified related to the responsive behaviour and removed. A number of days later, at a specified time, the resident demonstrated the specified responsive behaviour and was transferred to hospital for assessment.

Review of the licensee's specified Responsive Behaviour policy, identified specified interventions that were to be implemented when a resident demonstrated the specified

responsive behaviour.

During an interview with resident #001 on a specified date, the resident confirmed they had demonstrated the specified responsive behaviour and how they were able to implement the responsive behaviour that resulted in hospitalization.

During an interview with PSW #107, the PSW indicated they completed a specified intervention for resident #001, at specified intervals and indicated the resident no longer displayed a specified responsive behaviour.

During an interview with RPN #100, they indicated on a specified date and time, resident #001 was found with significant change in condition, due to a specified responsive behaviour. The RPN indicated they immediately notified RN #101 who also came to assess the resident and then the resident was transferred to hospital for assessment. The RPN confirmed awareness that the resident had a history of the specified responsive behaviour. The RPN indicated upon the resident's return from hospital, the resident was informed that staff would be implementing specified interventions and monitoring at specified intervals. The RPN indicated documentation was made to ensure the specified interventions were implemented.

During an interview with RPN #102, they indicated they received notification from resident #001's SDM on specified date and time, regarding concerns with the resident demonstrating a specified responsive behaviour. The RPN indicated the SDM requested a specified intervention to be performed. The RPN placed a note in the nursing communication book to have the intervention completed the next day and also notified the Home Area Manager (HAM #108), the NP and BSO staff regarding the SDM's concerns. The RPN indicated on a specified date and time, they discovered the specified intervention had not yet been completed and notified RN #106 to complete the specified intervention and reminded the RN of the resident's previous specified responsive behaviour. The RPN indicated the RN reported that the intervention was completed. The RPN indicated on a specified date (the day before the resident demonstrated the specified responsive behaviour), they discovered that no other interventions for resident #001 had been put in place. The RPN confirmed that the nursing communication book indicated on two specified dates, that the resident was placed on specified monitoring intervals upon return from hospital.

During an interview with RN #106, they confirmed RPN #102 had spoken to the SDM of resident #001 regarding their concerns. The RN confirmed that RPN #102 had requested

they complete a specified intervention as requested by the SDM and confirmed the intervention was not completed until the following date, or fully completed. The RN confirmed that no other actions were taken at that time. The RN indicated on a specified date, they were directed by RN #108 to complete a referral for a specialized service for resident #001, due to the SDM's concerns. The RN indicated the resident was agreeable with the referral, provided the RN with an item that was in their room that the resident was not supposed to have in their room and the item was removed. The RN indicated they reported the incident to RN #108., confirmed there were no assessments completed for resident #001 related to the specified responsive behaviour until a few days after the resident returned from hospital.

During an interview with Behaviour Supports Ontario (BSO-PSW #110), the PSW indicated they were made aware of resident #001 specified responsive behaviour, on a specified date (when the resident returned from hospital). The PSW indicated they implemented monitoring of the resident at specified intervals and completed a specified assessment. The PSW indicated no awareness of the resident's prior history of the specified responsive behaviour. The PSW indicated the nursing staff were also to implement a specified intervention. The PSW indicated they would be completing additional assessments and nursing staff were required to complete additional assessments for the specified responsive behaviour and update the resident's care plan.

During an interview with HAM-RN #108, they indicated awareness of resident #001's specified responsive behaviour history, had completed a specified assessment, placed the resident on increased monitoring with a specified BSO tool when the responsive behaviour occurred previously. RN #108 indicated not being aware of concerns from the resident's SDM regarding the specified responsive behaviour, prior to the resident's hospitalization. RN #108 indicated on a specified date, RN #106 reported concerns related to resident #001 and was notified at that time regarding the concerns from the resident's SDM. RN #108 indicated they then directed RN #106 to complete a referral for a specialized service. RN #108 confirmed they did not complete additional assessments and did not implement any increased monitoring of resident #001, until after the resident returned from the hospital. RN #108 indicated they also implemented an additional intervention and confirmed the resident's care plan had not been revised to include the additional interventions and should have been updated.

During an interview with the DOC, they indicated that the resident's SDM was more aware of the resident's specified responsive behaviour and had not shared the information with the home. The Inspector informed the DOC that the home was made

aware on a specified date. The DOC indicated that the specified intervention that was requested by the resident's SDM was not fully implemented. When the Inspector inquired about any other interventions implemented at that time, the DOC confirmed that no other interventions were implemented. The DOC confirmed that no assessments were completed at that time related to the specified responsive behaviour. The DOC indicated that the resident's plan of care would be revised when the resident returned to the home and the Inspector informed the DOC that the resident had already returned to the home, a few days earlier. During a later interview with the DOC, they indicated the home had a care conference after the resident returned from hospital, which included the resident, the resident's SDM and RN #108, to discuss the plan of care. The DOC indicated there were specified interventions and assessments implemented at that time, which included increased monitoring, at specified intervals. The DOC was not aware the resident was on different intervals of monitoring and that the specified assessments had not yet been completed.

There was no clear direction on the written plan of care for resident #001, to staff and others who provided direct care to resident #001, both before the resident went to hospital and after the resident returned from hospital, related to the specified responsive behaviour. There was no clear direction as to which assessments were to be completed and when, which additional interventions were to be used, including the level of monitoring intervals to be implemented and for how long, despite the resident having a prior history of the specified responsive behaviour and being notified by the resident's SDM of concerns related to changes in the resident's mood prior to the resident demonstrating the responsive behaviour that resulted in hospitalization.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2019_643111_0012
Log No. / No de registre :	007092-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 31, 2019
Licensee / Titulaire de permis :	St. Joseph's at Fleming 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	St. Joseph's at Fleming 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Rodd

To St. Joseph's at Fleming, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.6(1)(c).

Specifically,

1. Review and revise the written plan of care for resident #001 (and any other residents at risk for the specified responsive behaviours), to ensure there is clear directions to staff and other who provide direct care to the resident, specifically identifying the level of risk, risk factors/warning signs, level of monitoring to be used and duration, assessments to be completed, as indicated in the licensee's specified responsive behaviour policy.

2. Retrain registered nursing staff on the licensee's specified responsive behaviour policy, to ensure all staff are aware of their roles and responsibilities related to same. A written record to be kept of the retraining.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A critical incident report (CIR) was submitted to the Director for a medication incident/adverse drug reaction that occurred on a specified date. The CIR indicated RPN #100 went to resident #001's room at a specified time and found the resident with a significant change in condition. RN #101 also responded to resident #001's room and the staff determined the resident had a significant

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the information with the home. The Inspector informed the DOC that the home was made aware on a specified date. The DOC indicated that the specified intervention that was requested by the resident's SDM was not fully implemented. When the Inspector inquired about any other interventions implemented at that time, the DOC confirmed that no other interventions were implemented. The DOC confirmed that no assessments were completed at that time related to the specified responsive behaviour. The DOC indicated that the resident's plan of care would be revised when the resident returned to the home and the Inspector informed the DOC that the resident had already returned to the home, a few days earlier. During a later interview with the DOC, they indicated the home had a care conference after the resident returned from hospital, which included the resident, the resident's SDM and RN #108, to discuss the plan of care. The DOC indicated there were specified interventions and assessments implemented at that time, which included increased monitoring, at specified intervals. The DOC was not aware the resident was on different intervals of monitoring and that the specified assessments had not yet been completed.

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The scope was a level 1, only one resident was affected. The severity was a level 3, actual harm/risk as the resident was at risk for a specified responsive behaviour and was hospitalized. The compliance history was a level 3, one or more related non-compliance in last 36 months with LTCHA, 2007, s.6(1)(c) as follows:
-a Written Notification (WN) was issued on April 25, 2018 during inspection #2018_599166_0018.
-a WN was issued on October 27, 2016 during inspection #2016_360111_0020.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

(111)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jul 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office