Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2020	2020_815623_0019	010230-20, 015389-20, 015911-20	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

SARAH GILLIS (623)

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): October 19-23, 27 and 28, 2020

The following logs were inspected:
A Critical Incident Report for missing/unaccounted for controlled substance.
A Critical Incident Report for an allegation of verbal abuse.
A Critical Incident Report for a fall with injury.

On October 27 and 28, 2020 Inspector #194 was also present in the home to support Inspector #623 but did not inspect.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Manager of Quality & Education, Manager of Professional Practice, Home Area Manager(s) (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Nurse Practitioner (NP), Personal Support Workers (PSW), Care Assistants (CA), Maintenance, and residents.

The Inspector also reviewed the licensee's internal investigation records, residents clinical records, home specific policies, observed the delivery of resident care and services including staff to resident interactions, as well as observations of infection prevention and control measures in the home.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to

infection prevention and control measures specified in Directive #3, regarding active screening of people entering the home, the proper use of the surgical procedure mask and maintaining two meters distance from others, while not a wearing a mask in order to protect residents from COVID-19.

During the course of the inspection on multiple occasions the following was observed; Active screening was incomplete on three of the seven days upon entry and on all seven days upon exit, that the inspector was in the home. Physical distancing was not being maintained by residents in a group program in an identified home area. Multiple staff were observed daily throughout the home, to be within two meters of others with no surgical procedure mask or with the mask not covering their mouth and/or nose.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. As per the version of Directive #3 dated October 16, 2020, the Long-term care home must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19 with the exception of first responders, who should, in emergency situations, be permitted entry without screening. Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks. All staff of long-term care homes must always wear a surgical procedure mask for the duration of their shift. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical procedure mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19.

The Chief Executive Officer (CEO) and Director of Care (DOC) acknowledged that the expectation of the home was that all visitors would be properly screened, residents would be socially distanced where ever possible, staff would maintain proper social distancing and all staff/visitors would always properly wear a surgical procedure mask for the duration of their shift/visit in accordance with Directive #3.

The lack of adherence to Directive #3 related to active screening of people entering the home, the use of surgical/procedure mask and physical distancing presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective date October 16, 2020), observations throughout the home, and interview with the CEO, NP and DOC. [s. 5.]

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 by ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated staff member who co-ordinated the infection prevention and control program had the education and experience in infection prevention and control practices including infectious disease; cleaning and disinfection; data collection and trend analysis reporting protocols and; outbreak management.

During an interview the Nurse Practitioner (NP) indicated they were the designated lead for infection control in the home. The NP also indicated that they do not have specialized education or experience in infection prevention, outbreak management and control practices related to infectious diseases, cleaning and disinfecting, data collection and trend analysis.

The Director of Care (DOC) indicated that the NP was the designated lead for infection control in the home. The DOC indicated that they did not have specialized education or experience in infection prevention and control as required and they were not aware of anyone on staff who did have the required qualifications.

There is a risk that the required outbreak management and infection control practices may not be implemented when the designated infection prevention lead does not have the required infection prevention and control education.

Sources: Interview with the NP and DOC. [s. 229. (3)]

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 by ensuring that the designated staff member who co-ordinates the infection prevention and control program has the education and experience in infection prevention and control practices including infections diseases, cleaning and disinfection, data collection, trend analysis reporting protocols and outbreak management, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care plan for resident #001 was revised when the residents care needs changed or when the care set out in the plan was no longer necessary.

Critical Incident Report identified that resident #001 experienced an incident that caused an injury which resulted in a significant change in condition.

Resident #001's care plan for transfers, mobility and falls risk indicated that the resident required specific identified interventions.

Observations of resident #001; the resident was observed to be ambulating independently with the use of a specified assistive device, and did not require the specific identified interventions that were indicated in the care plan.

During an interview, PSW #106 and RN #109 indicated that resident #001 no longer required the use of specific identified interventions. The PSW and RN both indicated that the resident had been independent with transfers and ambulation for several weeks. The Home Area Manager (HAM) #102 indicated that the plan of care had not been updated for resident #001 when their care needs changed.

Sources: Resident #001's care plan, progress notes, assessments, observations of resident #001, and interview with PSW #106, RN #109 and HAM #102. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with or attempts to hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out the inspector's duties; 2017, c. 25, Sched. 5, s. 32 (1)
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3) or (3.1). 2017, c. 25, Sched. 5, s. 32 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Inspector was provided with access to the entire clinical health record for resident #001 when a manager in the home refused to enable access to Risk Management in Point Click Care (PCC), which interfered with the Inspector's ability to carrying out their duties.

On a specified date, Inspector #623 requested to be granted access to Risk Management in Point Click Care (PCC) where the home documents incidents involving resident's, including falls, responisve behaviour incidents and medication incidents. The following day, Inspector #623 was approached by RN #105 – Manager of Quality and Education who was accompanied by RN #110 – Manager of Professional Practice. RN #105 informed the Inspector that access to Risk Management in PCC would not be enabled as directed by the Director of Care (DOC). The DOC and Chief Executive Officer (CEO) were not present in the home at the time for consultation.

Sources: Interview with RN #105, RN #110 and the CEO. [s. 151. (a)]

Issued on this 16th day of December, 2020

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

Original report signed by the inspector.