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
Feb 23, 2021	2021_640601_0003	020798-20, 020827-20, 022936-20, 024456-20, 024553-20, 025933-20, 000172-21	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

KARYN WOOD (601)

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): January 27, 28, 29, February 2, 3, 4, 8, and 9, 2021.

Six logs related to a fall that resulted in a change in a resident condition.

A log related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Nurse Practitioner, (NP), Home Area Manager (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behaviour Support Ontario (BSO) PSW, Housekeeping Aide (HSK) and residents.

The inspector also reviewed applicable policies, resident health care records, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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 :

1. The licensee has failed to ensure that resident #002's plan of care included clear direction to staff about whether the resident required a safety device.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from the home regarding a fall that resulted in an injury. The CIS indicated the resident's plan of care following the injury was to have a specified safety device.

Home Area Manager (HAM) #101 indicated the resident had instructions on when to use the safety device to decrease their risk related to falls.

Observations of the resident identified the resident did not have the safety device in place. The resident's written plan of care did not include the instructions on when they required the safety device. Staff interviews identified they were not aware of the instructions on when the resident required the safety device. The resident was at risk for injury in the event of a fall due to the lack of clear direction for staff providing care to the resident related to when the safety device should be implemented.

Sources: CIS, resident's care plan, observations of the resident, and interviews with HAM #101 and other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #001's plan of care included clear direction to staff about whether the resident required a safety device.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from the home regarding a fall that resulted in an injury. The CIS indicated the resident's plan of care following the injury was to have a specified safety device.

Home Area Manager (HAM) #101 indicated the resident had instructions on when to use the safety device to decrease their risk related to falls.

Observations of the resident identified the resident did not have the safety device in place. The resident's written plan of care did not include the instructions on when they required the safety device. Staff interviews identified they were not aware of the instructions on when the resident required the safety device. The resident was at risk for injury in the event of a fall due to the lack of clear direction for staff providing care to the resident related to when the safety device should be implemented.

Sources: CIS, resident's care plan, observations of the resident, and interviews with HAM #101 and other staff. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program related to the use of personal protective equipment (PPE) and hand hygiene.

The long-term care home’s IPAC program included requirements for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident on contact and droplet precautions. The program specified that PPE worn in the room of a resident on contact and droplet precautions was to be removed when staff exited the room. Hand hygiene would be required using the five moments for hand hygiene technique after removal of the PPE, and prior to entering another resident’s bedroom.

A PSW was observed entering a resident’s bedroom, who required droplet and contact precautions according to the signage on the door. The PSW was wearing a mask, donned gloves, and a gown that did not cover the back of their uniform. The PSW was observed within two meters of the resident and was not wearing eye protection. The

PSW was observed exiting the resident's room with the same mask and removed their gloves and disposable gown at the same time. The PSW applied hand sanitizer to their hands but did not allow time for the product to dry or use proper technique to clean their hands. The PSW acknowledged that they should have removed the gloves before the disposable gown, and they were not aware they should have changed their mask upon exiting the isolation room.

A PSW was observed entering resident #010's room, who required droplet contact precautions according to the signage on the door. The PSW did not perform hand hygiene prior to donning the PPE or after doffing the PPE. The PSW was wearing a mask, donned gloves, and a gown that did not cover the back of their uniform and applied goggles. The PSW was observed exiting the resident's room and removed their gloves and disposable gown at the same time. The PSW placed the dirty goggles on a ledge located outside of the resident's room. The PSW was preparing to enter resident #011's room who was on contact precautions according to the signage on the door, by donning gloves. Inspector #601 reminded the PSW that hand hygiene was required. The PSW indicated they were busy, removed the gloves and applied hand sanitizer to their hands but did not allow time for the product to dry or proper technique to clean their hands prior to donning the gloves and PPE. The PSW was observed exiting resident #011's room and removed their gloves and disposable gown at the same time. The PSW placed the dirty goggles on a ledge located outside of the resident's room.

The Nurse Practitioner (NP) who is the infection control lead and the Home Area Manager (HAM) indicated that the expectation is that all staff participate in the IPAC program including wearing the proper PPE for identified isolation rooms, and follow the five moments of hand hygiene. The long-term care home's IPAC program included requirements for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident on contact droplet precautions and a gown and gloves for all contact with a resident on contact precautions. Upon exiting the isolation room all PPE is to be removed, a new mask is to be applied and dirty goggles are to be cleaned using disinfectant wipes. All staff are required to follow the Best Practice for donning and doffing of PPE as well as the mandatory masking protocol in Directive #3.

Two PSWs failed to participate in the implementation of the IPAC program which presented risk of infection to three residents.

Sources: Observations and interviews with two PSWs, HAM #113, and the NP, posted signage for three residents, the licensee's infection control policy for contact precautions,

policy for droplet precautions, and the Hand Hygiene policy. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 26th day of February, 2021

[redacted]

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

Original report signed by the inspector.