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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 08, 2021	2021_887111_0012 (A1) (Appeal\Dir#: DR# 154)	004006-21, 004560-21, 004824-21, 005918-21, 006630-21, 007252-21, 007545-21	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

Amended by Alain Plante (Director) - (A1)(Appeal\Dir#: DR# 154)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on September 08, 2021.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 154.
A copy of the Director Order is attached.

Issued on this 8 th day of September, 2021 (A1)(Appeal\Dir#: DR# 154)

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

Original report signed by the inspector.

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Alain Plante (Director) - (A1) (Appeal/Dir# DR# 154)
Inspection No. / No de l'inspection :	2021_887111_0012 (A1)(Appeal/Dir# DR# 154)
Appeal/Dir# / Appel/Dir#:	DR# 154 (A1)
Log No. / No de registre :	004006-21, 004560-21, 004824-21, 005918-21, 006630-21, 007252-21, 007545-21 (A1)(Appeal/Dir# DR# 154)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 08, 2021(A1)(Appeal/Dir# DR# 154)
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

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

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

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

(A1)(Appeal/Dir# DR# 154)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

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 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 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 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 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 8 th day of September, 2021 (A1)(Appeal/Dir# DR# 154)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Alain Plante (Director) - (A1) (Appeal/Dir# DR# 154)

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

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
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Licensee/Titulaire de permis

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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

Amended by Alain Plante (Director) - (A1)(Appeal/Dir# DR# 154)

Amended 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): June 22 to 25, 2021.

The following critical incidents (CI) were inspected concurrently during this inspection:

-Log #004560-21 related to an outbreak.

-Log #005918-21, Log #004006-21 and Log #006630-21 related to alleged staff to resident abuse.

-Log #007252-21, Log # 004824-21 and Log #007545-21 related to a fall with injury and transfer to hospital.

-Heating and Cooling requirements.

During the course of the inspection, the inspector(s) spoke with the Administrator, Home Area Managers (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN) , Personal Support Workers (PSW) , Registered Dietitian (RD) and residents.

During the course of the inspection, the inspector(s): toured the home, observed a meal service, reviewed resident health care records, falling star meeting minutes, employee records,line listings, surveillance records, home's investigations, air temperature records and the following policies: Prevention of Abuse, Infection Prevention and Control (Hand Hygiene) and Hot Weather Related Illness.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

5 WN(s)
4 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 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Housekeeper (HSK) was observed by the Inspector exiting resident #001's room while still wearing their gloves, did not perform hand hygiene, and then proceeded down the hall with their housekeeping cart, while still wearing the same gloves and entered another resident room. The same HSK was later observed exiting resident #009’s room and did not perform hand hygiene after exiting the residents room. Resident #007 had signage for contact and droplet precautions and the required PPE were available for staff use. A support staff was observed in the resident’s room for a period of time and wearing only a mask and eye protective wear. The support staff member then exited the room without doffing their mask or cleaning their eye protective wear, and did not perform hand hygiene. The support staff member confirmed awareness that resident #007 was on contact and droplet precautions but was not aware of the donning and doffing requirements. A short time later, a different support staff member was observed exiting the same residents the room without doffing their PPE or performing hand hygiene and walked down the hallway (past a number of resident rooms) and then returned to the resident's room and re-entered the room wearing the same PPE. Failure to implement IPAC practices, including donning and doffing PPE where required and completing hand hygiene, can lead to transmission of infections.

Sources: observations, Hand Hygiene policy and interview with staff. [s. 229. (4)]

2. The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home was declared in an outbreak by Public Health (PH) on a specified date, with a number of residents affected, and the outbreak was declared over a number of days later. Resident #010, #011 and #012 were affected in the outbreak and documentation revealed that they had not been monitored every shift for symptoms until the isolation was discontinued. The IPAC lead confirmed that residents were to be monitored every shift when on isolation and documented in the resident’s progress notes. Failing to monitor residents for symptoms every shift while on isolation precautions, may lead to change in symptoms not being identified or residents remaining in isolation longer than necessary.

Sources: CIR, Public Health line listing, progress notes for resident #010, #011 and #012 and interview of staff [s. 229. (5) (a)].

Additional Required Actions:

(A1)(Appeal/Dir# DR# 154)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

WN #2: 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure the care set out in the plan of care was provided to resident #005, as specified in the plan for responsive behaviours.

An RN and PSW #120 both witnessed PSW #104 being abusive towards resident #005. The resident later reported additional alleged abuse by the same PSW. Resident #005 demonstrated specified responsive behaviours and identified specified interventions to manage those responsive behaviours. The RN confirmed witnessing the incident and PSW #120 also confirmed that PSW #104 had not responded appropriately to the residents responsive behaviours. Failing to follow the resident's plan of care related to responsive behaviours can lead to staff to resident abuse.

Sources: CIR, observation and interview of resident #005, progress notes and care plan of resident #005, home's investigation and interview of staff.[s. 6. (7)]

2. The licensee failed to ensure the care set out in the plan of care was provided to resident #002, as specified in the plan for responsive behaviours.

An RPN reported witnessing PSW #104 being abusive towards resident #002 and then found the resident on floor. PSW #104 confirmed the resident had sustained a fall due to not following the resident's plan of care. The resident sustained an injury to a specified area as a result. The home's investigation concluded that PSW#104 had provided improper care and actions were taken as a result. Failing to follow the plan of care of resident #002, led to the resident sustaining a fall with

an injury.

Sources: CIR, observation and interview of resident #002, progress notes and care plan of resident #002, home’s investigation and interview of staff. [s. 6. (7)]

3. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised, because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care for resident #001 related to falls.

Over a number of months, resident #001 sustained a number of un-witnessed falls. All of the falls resulted in injuries and a number of the falls resulted in transfer to hospital for assessment and resulted in a significant change in condition. Resident #008 was observed by the Inspector assisting resident #001 with an unsafe transfer, activating their alarming device and removed the resident from their room. The resident's alarming device had not been put in place on their mobility aid. An RPN responded to the alarming device and determined the resident had already left the room and turned off the alarming device. A short time later, resident #001 was observed in their mobility aid in a specified area with the alarming device in place. Resident #001 was again observed attempting to self transfer to provide the mobility aid to resident #008 and staff were called for assistance. Resident #001 was at risk for falls and had specified falls prevention interventions identified. There was no indication of interventions related to resident #008 who was observed with resident #001 on multiple occasions and would assist the resident in unsafe transfers. Interview with staff confirmed awareness that resident #008 was observed on a number of occasions to be assisting the resident with unsafe transfers. There was no indication the plan of care was revised and other interventions considered or interventions surround the unsafe transfers involving resident #008.

Sources: CIR's, progress notes, post fall assessments and care plan for resident #001, Falling star meeting minutes, observation and interview of resident #001, and interview of staff. [s. 6. (11) (b)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.2) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1.2).

Findings/Faits saillants :

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was evaluated and updated, at a minimum, annually in accordance with evidence-based practices.

On May 15, 2021, amendments to LTCHA, under O. Reg. 79/10, related to enhanced cooling requirements came into force. The Environmental Services Manager (ESM) was not aware of the new changes to the heat related illness policy and confirmed the policy had not been updated. Failure to implement changes to cooling requirements in the homes places the residents at risk for heat related illness.

Sources: Hot Weather Monitoring policy (2.3-35) revised January 2021; Amendments to Ontario Regulation 79/10 (Regulation) Under the Long-Term Care Homes Act, 2007 (LTCHA) Related to Enhanced Cooling Requirements, came into force on May 15, 2021 and interview with staff (ESM).

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 the heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The air temperatures in the home were to be monitored once every morning, every afternoon between 12 and 5 PM and every evening or night in at least two resident rooms and in a common area on every floor. The air temperatures in the home were monitored daily in one resident room and daily in a common area on each floor. The ESM confirmed they were unaware of the new changes to the legislation. Failing to monitor air temperatures as required can lead to temperatures under 22 C or exceeding 26 C being undetected and leading to residents having possible heat-related illness or being too cold.

Sources: Hot Weather Monitoring policy (2.3-35) reviewed January 2021, Air temperature logs and interview with staff (ESM).

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 the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of or that is reported to the licensee, had appropriate action taken in response to every such incident.

An RN and a PSW witnessed PSW #104 being abusive towards resident #005. The resident later reported additional abuse by PSW #104. The home's investigation indicated the allegation was concluded as unfounded, PSW #104 was to have retraining provided and the retraining had not yet been completed. Failing to take appropriate actions in response to incidents of staff to resident abuse can lead to further incidents of abuse of residents.

Sources: CIR, home's investigation, interview of resident #005, review of progress notes of resident #005, and interview of staff.

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, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated and (b) appropriate action is taken in response to every such incident, to be implemented voluntarily.

Issued on this 8 th day of September, 2021 (A1)(Appeal/Dir# DR# 154)

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

Original report signed by the inspector.