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 10, 2022	2021_885601_0022	011753-21, 011795-21, 011924-21, 014625-21, 015212-21, 016111-21, 018054-21	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), ANGIEM KING (644)

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): December 2, 3, 6, 7, 8, 9, 10, 14, and 15, 2021.

The following intakes were completed in this Critical Incident System (CIS) Inspection:

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

A log related to an improper transfer of a resident.

NOTE: A Voluntary Plan of Correction related to s. 6 (7) of the LTCHA was identified in this inspection and has been issued in a concurrent complaint inspection, #2021_885601_0023.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Resident Care (DRC), Home Area Manager (HAM), Infection Prevention and Control (IPAC) lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspectors also reviewed resident clinical health care records, relevant home policies and procedures, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services

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

2 WN(s)
1 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 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 a resident was transferred safely when a PSW did not have a second staff member present when they were transferring the resident.

The Ministry of Long-Term Care received a Critical Incident System (CIS) report regarding allegations of incompetent or improper treatment that placed a resident at risk for harm. A PSW was transferring the resident out of the bathtub using the mechanical lift without a second staff member present and the resident slid out of the sling and landed on the floor. According to the Home Area Manager (HAM), the resident was not injured and the internal investigation determined the PSW had not followed the licensee's lift and transfer policies when the PSW did not have a second staff member present while using the mechanical lift. The licensee lift and transfer policy directs that two staff members must be present when using the mechanical lifts to ensure safety of the resident. The resident was at actual risk for injury when two staff did not assist with the resident's transfer as one staff member is required to guide the resident to their destination and the second staff member is required to operate the control and maneuvering the lift to ensure the resident's safety.

Sources: Review of a CIS, progress notes, care plan, internal investigation, Safe Work Practice Medi-lift – Mechanical lift - Full lift, Safe Work Practice, Sling Application for Total Mechanical Lift, Mechanical Lifts – Do's and Don't, and interview with a HAM. [s. 36.]

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 every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the report made in writing to the Director included setting out the long-term actions planned to correct the situation and prevent recurrence when the resident was re-admitted to the home.

A review of the resident records indicated that they had a fall that resulted in an injury. A review of the Critical Incident Report (CIR) indicated that this incident was reported to the Director with no amendment to the CIR on the resident’s readmission to the home. The CIR under analysis and follow-up indicated to correct the situation and prevent recurrence was to be determined upon the resident's return to the home. An interview with the Manager of Professional Improvement (MPI) indicated the reason the home had not amended the CIR on the resident’s return to the home was because of a miscommunication with HAM who was to update the CIR. The MPI acknowledged they should have informed the Director, with the long-term actions planned to prevent recurrence of falls when the resident was re-admitted to the home. There was no risk of harm as result of not reporting of the follow-up actions.

Sources: Review of a CIS, progress notes and care plan for the resident; interview with MPI. [s. 107. (4) 4.]

Issued on this 22nd day of February, 2022

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

Original report signed by the inspector.