



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

**Rapport d'inspection  
prévue le *Loi de 2007  
les foyers de soins de  
longue durée***

**Ministry of Health and Long-Term Care**  
Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Ottawa Service Area Office  
347 Preston St., 4<sup>th</sup> Floor  
Ottawa ON K1S 3J4

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
Ottawa ON K1S 3J4

**Ministère de la Santé et des Soins de  
longue durée**

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Division de la responsabilisation et de la performance du  
système de santé  
Direction de l'amélioration de la performance et de la  
conformité

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<b>Date(s) of inspection/Date de l'inspection</b> Mar 11, 2013	<b>Inspection No/ d'inspection</b> 2013_195166_0012	<b>Type of Inspection/Genre d'inspection</b> Complaint
<b>Licensee/Titulaire</b> MARYCREST HOME FOR THE AGED 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8		
<b>Long-Term Care Home/Foyer de soins de longue durée</b> ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b> CAROLINE TOMPKINS (166)		
<b>Inspection Summary/Sommaire d'inspection</b>		



The purpose of this inspection was to conduct a Complaint Inspection.

This inspection was conducted on the following date(s): March 4, 2013, with additional interviews conducted on June 10, 2013 and July 22, 2013.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the Director of Care, the Unit Manager, Registered staff, Personal Support staff and Housekeeping staff.

During the course of the inspection, the inspector(s) observed residents, reviewed residents' clinical care records and the licensee's policies: #14-18, Abuse and Neglect, #14-60, Behaviour Management and #8-07, Aggressive Incident Report.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

### NON-COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

WN – Written Notifications/Avis écrit  
VPC – Voluntary Plan of Correction/Plan de redressement volontaire  
DR – Director Referral/Régisseur envoyé  
CO – Compliance Order/Ordres de conformité  
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive Behaviours**



**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**

**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**

**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**

**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that strategies were developed and implemented for Resident #1, who demonstrates responsive behaviours.

-MDS assessment, clinical documentation and interviews with staff indicate that, Resident#1, frequently refuses to take prescribed medications and has had changes in visual, communicative, physical and cognitive status. Due to these changes the resident's reaction, when not understood or perceives a threat to personal space is defensive, verbally and physically aggressive. [s. 53. (4) (b)]

***Additional Required Actions:***

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

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the right of Resident #2, to be protected from abuse, was fully respected and promoted:

On an identified date, Resident #1, while sitting in the wheelchair forcefully pushed back the chair and Resident #2 fell and sustained a fractured hip. [s. 3. (1) 2.]



The staff who witnessed the fall was interviewed on March 4, June 10 and July 22, 2013. During the interview of July 22, 2013, the staff member stated to inspector she would not use the word violent, but that she did use the word aggressive to describe the incident in the progress note.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. On an identified date, Resident #1, while sitting in the wheelchair pushed back the chair and Resident #2 fell and sustained an injury. Interview with the Director of Care indicates the licensee did not notify the police of this incident. Interview with the Power of Attorney(POA)for Resident #2 establishes that the police were notified by the Resident #2's family. [s. 98.]

**Issued on this 11th day of March, 2013  
Amended on December 19, 2013 (#194)**

[copy above table for each WN, changing the WN number as appropriate]

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. <i>Chantal Lafreniere (194)</i> FOR: <i>Caroline Lompkins (166)</i>
Title: _____ Date: _____	Date of Report: (if different from date(s) of inspection). <i>Dec 19 / 2013</i>



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
des Soins de longue durée

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*

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) /

Nom de l'inspecteur (No) : CAROLINE TOMPKINS (166)

Inspection No. /

No de l'inspection : 2013\_195166\_0012

Log No. /

Registre no: O-00155-13

Type of Inspection /

Genre d'inspection: Complaint

Report Date(s) /

Date(s) du Rapport : Mar 11, 2013

Licensee /

Titulaire de permis : MARYCREST HOME FOR THE AGED  
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 : ~~GARY SIMS~~ Alan Cavella

To MARYCREST HOME FOR THE AGED, you are hereby required to comply with  
the following order(s) by the date(s) set out below:



Ministry of Health and  
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Ministère de la Santé et  
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Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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de soins de longue durée*, L.O. 2007, chap. 8

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**Order # /**  
**Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

- (a) the behavioural triggers for the resident are identified, where possible;
- (b) strategies are developed and implemented to respond to these behaviours, where possible; and
- (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The licensee shall ensure that, for Resident #1 who demonstrates responsive behaviours, strategies are developed and implemented to respond to these identified behaviours.

**Grounds / Motifs :**

1. MDS assessment, clinical documentation and interviews with staff indicate that, Resident #1, frequently refuses to take prescribed medications and has had changes in visual, communicative, physical and cognitive status. Due to these changes, the resident's reaction, when not understood or perceives a threat to personal space is defensive, verbally and physically aggressive.

(166)

**This order must be complied with by /**  
**Vous devez vous conformer à cet ordre d'ici le :** Mar 14, 2013



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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

### 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 or by fax upon:

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



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**Ordre(s) de l'inspecteur**  
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de soins de longue durée*, L.O. 2007, chap. 8

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
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](http://www.hsarb.on.ca).





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Order(s) of the Inspector  
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Ministère de la Santé et  
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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  
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## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

### PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 11th day of March, 2013**

**Signature of Inspector /  
Signature de l'inspecteur :**

**Name of Inspector /  
Nom de l'inspecteur :**

CAROLINE TOMPKINS

**Service Area Office /**

**Bureau régional de services :** Ottawa Service Area Office