Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 16, 2013	2013_179103_0034	O-000436-13	Critical Incident System

Licensee/Titulaire de permis St. Joseph's at Fleming,

(fka) MARYCREST HOME FOR THE AGED
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

DARLENE MURPHY (103)

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): July 9-11, 2013

During the course of the inspection, the inspector(s) spoke with Health care aides, Registered staff, the Dietician, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records and made resident observations.

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

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 :

1. The licensee has failed to comply with LTCHA, 2007, s. 23 (1) (a) whereby an alleged, suspected or witnessed incident of abuse of a resident was not immediately investigated.

Administrator, Alan Cavell, was interviewed in regards to a critical incident submitted by the home on an identified date. During the meeting, the family member expressed concerns that there had been conflicting stories reported by different staff members in regards to injuries Resident #1 had received.

Cavell advised that following the meeting, he went and spoke with the staff working on the resident's unit and concluded there was no evidence of abuse after the discussion with staff.

The family later notified police in regards to the injuries of unknown cause. The home was unable to produce any notes in regards to the investigation into the allegations of abuse.

At the time of this incident, a Compliance Order for LTCHA, 2007, s. 23 (1) (a) had already been issued and was returned to compliance on June 3, 2013. [s. 23. (1) (a)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 24 (1) whereby an allegation of resident abuse was not immediately reported to the Director.

On an identified date, Administrator, Alan Cavell, met with a family member of Resident #1. During the meeting, the family member expressed concerns that there had been conflicting stories about injuries the resident had received. These allegations were not reported to the Director until six days later when a critical incident was submitted by the home.

At the time of this incident, a Compliance Order for LTCHA, 2007, s. 24 (1) had already been issued and remains outstanding at the time of this inspection. [s. 24. (1)]

WN #3: 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 comply with O. Reg 79/10 s. 36 whereby the licensee failed to ensure staff used safe transferring techniques when assisting residents.

Resident #1's progress notes were reviewed. On an identified date, it was documented that two staff were transferring the resident from the wheelchair to the bathroom using a mechanical lift. During the transfer, the resident sustained an injury.

The staff failed to ensure the resident's safety during the transfer. [s. 36.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 50 (2) (b) (iii) whereby a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was not assessed by a registered dietician who is a member of the staff of the home.

Resident #1's treatment administration records (TARS) were reviewed for four months. This resident has been receiving skin care treatments throughout this time frame.

The Dietician was interviewed and stated she is involved with Resident #1 for weight loss, but was unaware the resident had any skin impairments. She stated she has never received a referral to assess the resident in regards to the skin. [s. 50. (2) (b) (iii)]

Issued on this 16th day of July, 2013

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