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_200148_0024	O-000352-13	Complaint

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 10, 11 and 12, 2013

This inspection also included data related to a Critical Incident under Log O-000657-13.

During the course of the inspection, the inspector(s) spoke with Director of Care, two Unit Managers, Registered Dietitian, Resident Care Coordinator, Registered Nursing Staff, Food Service Workers and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident health care records, reviewed a Risk Management Report, bath records/schedule and food and fluid records. In addition several meal observations were conducted on the Woodland Unit.

The following Inspection Protocols were used during this inspection:
Dining Observation

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.8 (1) (b), in that the licensee failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

On July 12, 2013 during the breakfast meal service on Woodland, Resident #7 was observed to be provided total feeding assistance. At one point during the meal service the Personal Support Worker (PSW) responsible for feeding the resident left the dining room for a staff break at approximately 9:15am. Resident #7 was left with a full meal and 2 glasses of fluid, the resident was not observed to feed self during the staff absence. Upon the staff members return at approximately 9:30am the staff member commented that the resident hadn't eaten much of the meal. The staff member then provided feeding assistance and Resident #7 completed the meal.

The plan of care for Resident #7 indicates that the resident requires total feeding assistance.

On July 12, 2013 during the later part of the breakfast meal service on Woodland, Resident #9 was observed with toast and fluids and Resident #10 was observed with fluids, the resident's were not feeding themselves and no one was providing feeding assistance. The Registered Practical Nurse (RPN) in the dining room, reported that this unit was short one staff member today and another had gone on break, she was present in the dining room to supervise until a PSW returned.

The plan of care for Resident #9 and #10 indicates that the residents require extensive to total feeding assistance.

The program of personal support services for the home was not organized to meet the assessed needs of Resident #7, #9 and #10. [s. 8. (1) (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 program of personal support services is organized to ensure the provision of resident feeding assistance needs, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (7), in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A physiotherapy assessment conducted on a specified date, indicated that Resident #11 requires 2 person assist when ambulating.

On a specified date, Resident #11 was found alone after sustaining a fall that resulted in injury.

The plan of care related to the resident's need for assistance when ambulating was not provided as set out in the plan of care on the specified date.

At the time of this incident, a Compliance Order for LTCHA, 2007, s. 6(7) had already been issued and remains outstanding at the time of this inspection. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.33(1), in that the licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

A review of bath records for the Woodland unit between the dates of April 24 and 30, 2013, indicated that 6 residents were not bathed, at minimum, twice a week.

A review of bath records for the Woodland unit between the dates of July 1 and 7, 2013 indicated that all residents residing on the Woodland unit were bathed, at minimum, twice a week. [s. 33. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 73 (2) (a), in that the licensee did not ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

During the Woodland supper meal service on July 10, 2013 a staff member was observed to be responsible for providing feeding assistance to a table of four residents (Residents #1, #2, #3 and #4). The staff member was observed to provide total feeding assistance to Resident #1. The staff member was observed to provide intermittent physical feeding assistance to Resident #2 and #3, neither resident was observed to feed themselves. Resident #4 was able to feed self.

The plan of care for Resident #1, #2 and #3 indicates that all three residents require total feeding assistance.

A person was observed to simultaneously assisted more than two residents who needed total assistance with eating or drinking. [s. 73. (2) (a)]

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Issued on this 16th day of July, 2013

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

Amanda Nui RD LTCH Inspector