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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2013	2013_031194_0046	001093-13	Complaint

Licensee/Titulaire de permis

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 13 & 14, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Unit Manager(UM), Registered Practical Nurse(RPN), Behavioural Support Ontario(BSO)staff, Personal Support Worker(PSW),Physician, and complainant.

During the course of the inspection, the inspector(s) Reviewed identified residents clinical health records, internal incident reports, licensee's policy of "Falls Prevention and Management Program" #8-41, observed the identified resident and the staff/resident provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee failed to comply with LTCHA, 2007 s. 6(11)b when the plan of care for Resident #1 was not revised and different approaches considered when the care set out in the plan of care for the prevention of falls was not effective.

Resident #1 is a cognitively impaired individual at risk for falls related to an unsteady gait and poor judgement. Since changes to the plan of care Resident #1's responsive behaviours have increased. There have been eight incidents of responsive behaviour between other residents and three additional incidents involving staff resulting in injury. Resident #1 is frequently directed to the bedroom by staff and left alone with the door closed. This practice is increasing the risk of un-witnessed falls in the room.

-PSW #2 has described resident #1 as being at risk for falls related to poor judgement when attempting to sit. PSW #2 states that resident #1 frequently will have to be guided to sit properly in a chair.

-On two identified dates the progress notes and internal incident reports confirm that resident #1 fell while in the room alone. No injuries are noted with the first fall, but resident #1 suffered an injury with the second fall. There is no known cause for the un-witnessed falls described in the incident reports.

In a previous inspection involving resident #1 the licensee was issued a Written Notification WN and a Voluntary Plan of Correction VPC related to falls under s. 6(11) b. The report provided to the licensee outlined several scenario's where the resident was at risk for falls when left in the room. The report stated "the resident remains at risk of falls when left alone in the room with the door closed." "New approaches would need to be considered in the revision of the plan of care as it relates to fall prevention"

The inspector requested information related to the VPC for this non compliance. The DOC explained that the licensee had attempted to contact an outside provider for the purpose of acquiring equipment for resident #1. At this time no equipment has been provided. The written plan of care for resident #1 identifies a risk for falls, no revision to the plan of care or new approaches have been noted since the previous non compliance was issued.

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s. 31 (3)(a) to provide a nursing staffing mix that is consistent with resident's assessed care and safety needs.

The home has described the nursing leadership roles to include a Director of Care, 2 Unit Managers, Charge Nurses and Registered Practical Nurses on the units.

During a complaint inspection for a responsive behaviour of a resident and a critical incident inspection related to a resident abuse the following was identified:
- The Director of Care stated that the BSO team had been requested to review a resident identified as having responsive behaviours. At the time of the inspection the BSO team confirmed that the resident was not being followed by the team.
- The Unit Manager advised the inspectors that her role is managerial not clinical and that the Charge Nurse does not report resident care information to her. As a result, she was not able to provide or locate important details related to the investigation of the reported incident of abuse.
- The Director of Care and the Unit Manager were unable to provide information to the inspectors related to safety concerns of a resident, having no knowledge of the sign in/out practices for this resident.
- The Charge Nurse was not familiar with the outcome of a recent DOS (Dementia Observation System) monitoring period for an identified resident's recent behaviours.
- The Registered Practical Nurse focus is on medication administration.
- An identified resident's family have expressed frustration and concerns related to the communication about the resident's condition, care needs and incidents.

The information provided from the nursing leadership "staffing mix", related to high risk resident care and safety needs is often conflicting and fragmented, with each level of nursing only capable of responding to a portion of the care for the resident. [s. 31. (3) (a)]

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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

Issued on this 22nd day of November, 2013

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

Chantal Lafleur (194)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2013_031194_0046
Log No. / Registre no:	001093-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 20, 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 :	Paul O'Krafka

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The plan of care for resident #1 shall be revised and different approaches for the prevention of falls are to be implemented

Grounds / Motifs :

1. There was no indication that the plan of care for resident #1 was revised and different approaches considered when the care set out for the prevention of falls was not effective.

Resident #1 is a cognitively impaired individual at risk for falls related to an unsteady gait and poor judgement. Since changes to the plan of care Resident #1's responsive behaviours have increased. There have been eight incidents of responsive behaviour between other residents and three additional incidents involving staff resulting in injury. Resident #1 is frequently directed to the bedroom by staff and left alone with the door closed. This practice is increasing the risk of un-witnessed falls in the room.

-PSW #2 has described resident #1 as being at risk for falls related to poor judgement when attempting to sit. PSW #2 states that resident #1 frequently will have to be guided to sit properly in a chair.

-On two identified dates the progress notes and internal incident reports confirm that resident #1 fell while in the room alone. No injuries are noted with the first

fall, but resident #1 suffered an injury with the second fall. There is no known cause for the un-witnessed falls described in the incident reports.

In a previous inspection involving resident #1 the licensee was issued a Written Notification WN and a Voluntary Plan of Correction VPC related to falls under s. 6(11)b. The report provided to the licensee outlined several scenario's where the resident was at risk for falls when left in the room. The report stated "the resident remains at risk of falls when left alone in the room with the door closed." "New approaches would need to be considered in the revision of the plan of care as it relates to fall prevention"

The inspector requested information related to the VPC for this non compliance. The DOC explained that the licensee had attempted to contact an outside provider for the purpose of acquiring equipment for resident #1. At this time no equipment has been provided. The written plan of care for resident #1 identifies a risk for falls, no revision to the plan of care or new approaches have been noted since the previous non compliance was issued.

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2013

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

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.

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, 11e 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.

Ontario

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

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.

Issued on this 20th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Chantal Lafreniere (194)

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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