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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2014	2014_196157_0005	000113-14, 000076-14	Critical Incident System

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

PATRICIA POWERS (157)

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): February 14, 18, 2014

The following Critical Incidents were inspected: CI #2935-000001-14 (Log#O-000113-14); CI #2935-000003-14 (Log#O-000076-14)

During the course of the inspection, the inspector(s) spoke with the CEO, Director of Care(DOC), Behaviour Support Ontario(BS0), Quality Facilitator, Registered Practical Nurses (RPN), Unit Managers and residents.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, reviewed facility policies/procedures related to abuse and responsive behaviours, reviewed BSO procedures and assessment records, MDS Assessments for identified residents, observed resident care practices and observed staff to resident interactions.

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

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. Related to Log#O-000076-14 - CI#2935-000003-14
The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #03 related to the resident's responsive behaviours.

Progress notes for resident #03 indicate that the following incidents occurred:
- On an identified date, resident #03 was observed to be agitated and demonstrated a responsive behaviour towards resident #04. Staff approached and removed resident #03 from the room.
- On an identified date, a PSW reported that resident #03 demonstrated a responsive behaviour towards her.

Staff #107 confirms that resident #03 is being provided private support services for specified dates and hours.

The written plan of care for resident #03, last reviewed February 17, 2014 indicates that the resident demonstrates an identified responsive behaviour and provides interventions to prevent this behaviour.

The resident's plan of care fails to:
- provide clear direction related to the specific nature of the responsive behaviour as demonstrated by the resident in two identified incidents.
- identify the presence and role of a private support service provider. [s. 6. (1) (c)]

2. Related to Log#O-000113-14 - CI#2935-000001-14
The licensee failed to ensure that the care provided to resident #01 was provided to the resident as specified in the plan.

Progress notes for resident #01 indicate that the following incident occurred:
On an identified date resident #01 was physically resistant to the care being provided by staff. Staff continued to provide care despite the resident's opposition, resulting in injury to a staff member.

The current plan of care for resident #01 directs that, if the resident is resistive to care,
- staff should give space and reassurance, re-approach, have another staff member approach
- allow for flexibility in resident's routine

- leave resident and return in 5 - 10 minutes

Staff providing care for resident #01 failed to give the resident space, reapproach, have another staff member approach or leave the resident and return in 5-10 minutes. Staff #104 involved in the incident stated that the resident was taking the time of two staff members during the meal period and there are only four staff members in the dining room. Therefore, there was not time to manage the situation differently. [s. 6. (7)]

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 plan of care for resident #03 sets out clear directions to staff and others who provide direct care to the resident related to the resident's responsive behaviours
- the care provided to resident #01 is provided to the resident as specified in the plan, to be implemented voluntarily.

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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log#O-000113-14 - CI#2935-000001-14
The licensee failed to ensure that the suspected abuse of a resident that resulted in harm to the resident was not immediately reported to the Director.

Progress notes for resident #01 and resident #02 and Critical Incident report 2935-00001-14, indicate that on an identified date an altercation between resident #01 and resident #02 resulted in a physical injury to resident #02.

There is no indication that the Director was immediately notified of this incident resulting in harm to resident #02. [s. 24. (1)]

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 a person who has reasonable grounds to suspect the abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, immediately reports the suspicion and the information upon which it is based, to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Related to Log#O-000113-14 - CI#2935-000001-14
The licensee failed to ensure that medications were administered to resident #01 in accordance with the directions for use specified by the prescriber.

The physician's order for resident #01 on an identified date directs a dosage change in the resident's medications.

Medication Administration Records (MAR) for resident #01 for an identified month indicate the prescribed medication change.

The MAR indicates that the prescribed medications were not administered as ordered by the physician on 6 occasions over an identified 3 day period.

Codes entered in the MAR indicate "drug not available" on the identified dates and times.

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 medications are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 21st day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Pat Powers #157