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
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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 27, 2013	2013_226192_0021	L-000679-13, L-000684-13	Critical Incident System

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

Long-Term Care Home/Foyer de soins de longue durée

ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY
255 St. Andrew's Street, CAMBRIDGE, ON, N1S-1P1

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 27, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Registered Practical Nurse, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, investigation findings and observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are not neglected by the licensee or staff.

In 2013 resident #001 was provided a medical device by a Personal Support Worker (PSW) of the home. Interview confirms that the PSW communicated to other staff of the home that the resident continued to use the device, prior to the end of her shift. The resident rang their call bell for assistance, requesting the medical device approximately three hours later and the device was found to be place. Interview confirms that no staff member of the home removed the device from resident #001 after it was placed three hours earlier.

Resident #001 sustained redness on their skin as a result of using a specified medical device for a period of approximately three hours. The redness did resolve without breakdown of the skin tissues.

Resident #001 failed to receive the care or assistance they required, resulting in redness to their skin, as a result of inaction of staff when they were left on a medical device for a period of approximately three hours in 2013. [s. 19. (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 ensuring that residents are not neglected by the licensee or staff, 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident.

Staff and resident interview confirm that the resident requests and is provided a medical device at night.

Record review and interview confirm that the plan of care does not include that resident #001 may request use of a medical device for continence needs when in bed.

The plan of care does not set out the planned care for resident #001. [s. 6. (1) (a)]

Issued on this 28th day of November, 2013

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

Debora Saville (192)