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
Apr 10, 2014	2014_355000_0003	L-000349-14	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

CHRISTINE MCCARTHY (588)

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): April 8, 9, 2014

This inspection was conducted concurrently with inspection L-000294-14. Debora Saville Long Term Care Homes Inspector #192 participated in this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Practical Nurse, Behaviour Support staff, Personal Support Worker, and the resident.

During the course of the inspection, the inspector(s) reviewed the medical record, incident investigation notes, and policy and procedure.

The following Inspection Protocols were used during this inspection: 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 VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

In 2014 a visitor of resident #001 informed a member of the staff of the Home, of an injury to resident #001 and alleged that the resident had been abused by a person in the morning.

During the home's investigation related to the allegation of abuse, it was identified that during the bath, in 2014, resident #001 was identified to have an injury.

Documentation review and interview confirm that the presence of an injury to resident #001, was not included in the documentation completed in 2014 on the Bath Record and Skin Assessment form or within the progress notes.

Interview with the Director of Care (DOC) and policy review, confirm that changes in a resident's skin condition should be identified on the Bath Record and Skin Assessment form and within the progress notes in Point Click Care. The DOC also indicated that changes in skin condition should be reported to registered staff who would also be responsible for documenting the change.

An injury evident in 2014 during bathing, was not documented or communicated to the registered staff until the investigation initiated in 2014 related to the allegation of abuse directed at resident #001. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of an alleged incident of abuse of the resident that resulted in a physical injury or pain to the resident.

A visitor of resident #001 reported in 2014 that the resident alleged a person providing care in the morning, caused an injury to the resident.

Record review and interview confirm that the Substitute Decision Maker for resident #001 was not notified immediately of the allegation of abuse which was reported to staff and investigated by the home in 2014.

The Substitute Decision Maker was not notified by the Home of an allegation of abuse reported by resident #001 [s. 97. (1) (a)]

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Issued on this 10th day of April, 2014

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

CHRISTINE McCARTHY #588