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
Sep 13, 2013	2013_226192_0007	L-000659-13, L-000660-13	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): August 30, 2013 and September 13, 2013

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

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

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

Personal Support Services

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

In July 2013 resident #001 received a treatment and was not provided assistance to the bathroom by the staff member providing the treatment.

Interview identified that the resident was provided the treatment and was left on the bed without clothing from the waist down. The continent resident became distressed by the need to go into the bathroom and was assisted by a visitor in attendance.

The resident was not provided treatment with courtesy and respect and in a way that respected their dignity.

Previously issued December 2010 as a CO, complied May 2013. [s. 3. (1) 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 the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is complied with.

A) The home's bowel protocol indicates that a resident whose bowels have not moved for five days would receive a fleet enema after receiving a suppository on day four with no bowel movement and oral stool softener on day two and three with no bowel movement.

Resident #001 received a treatment in 2013. The home's bowel protocol was not followed in that the resident had not received the prescribed treatment for day two, three or four prior to receiving the treatment for day five.

A review of the bowel record and interview with the Director of Care confirms that a specified date in 2013 was the resident's second day without a bowel movement and they should have received a stool softener at that time.

B) The home's policy Bowel Protocol - Suppositories/Enemas Policy number 2.6.2.9 reviewed on January 19, 2012 states:
Procedure for fleet enema:
13. The resident is to be aided to hold the enema solution until he/she gets to the bathroom or on the bedpan.
14. Offer assistance to the bathroom or place on bed pan as is necessary.
15. Stay nearby in case resident should become faint. Be sure call bell is within easy reach.

In 2013 resident #001 was given an enema. Interview confirms that the resident was left on the bed following the enema and was not assisted to the bathroom or bedpan. The family friend, in attendance at the time, assisted the resident to the bathroom.

It is noted that prior to the completion of this inspection the home took action to prevent a re-occurrence of the actions identified in this area of non-compliance, by a specified staff member. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Resident #002 was assisted to the dining room in a night gown in August 2013.

Interview with a visitor who observed the resident identified that the resident was dressed in a night gown that gaped open at the top each time the resident leaned forward and that the resident was seated in common areas of the home.

Review of the progress notes does not indicate that the resident was resistive to staff attempts to dress.

The plan of care indicated that the staff were to ensure the resident was dressed properly as they would often attempt to dress/undress themselves throughout the day.

Interview with the Director of Care confirms that a night gown would be inappropriate clothing to be worn to the dining room.

Staff of the home failed to ensure that resident #002 was dressed appropriately, suitable to the time of day and for attendance in the dining room in August 2013. [s. 40.]

Issued on this 13th day of September, 2013

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

Debora Saville (192)