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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2016	2016_214146_0002	018343-15, 001488-16	Critical Incident System

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

BARBARA NAYKALYK-HUNT (146)

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): January 27, 28, 2016.

Two Critical Incident inspections (CI) #018343-15 and #001488-16 related to choking were conducted concurrently along with Follow-up inspection #021711-15. Non-compliance related to the CI Inspections are included in this report. Inspector Heather Preston shadowed.
During the course of this inspection, the inspector reviewed residents' health records, policies and procedures, the home's internal investigation notes related to the incidents and observed dining service and resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Supervisor, Director of Resident Services, Food Service Manager (FSM), registered staff, Personal Support Workers (PSW'), dietary staff and residents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident.

Resident #200's written plan of care for January 2016 was reviewed. Under the focus of Activities of Daily Living (ADL) function, staff were directed to avoid the use of a specific strategy. Under a different focus in the same plan of care , staff were directed to use the specified strategy. The directions were conflicting and unclear. RPN #003 stated that the strategy was not used. Registered staff and the ADOC confirmed that the written plan of care's directions to staff related to the use of the specified strategy was unclear. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

Resident #100's plan of care directed staff that the resident was to be monitored during a specified activity. A progress note written by RPN #002 for resident #100 indicated that the resident was not monitored during the specified activity on an identified date in August 2015.
When RPN #002 was interviewed, the nurse confirmed that the nurse was not aware of the resident's plan of care although it was accessible. The DOC confirmed that the nurse should have been aware of the contents of the resident's plan of care. [s. 6. (8)]

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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 16th day of February, 2016

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

Original report signed by the inspector.