Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 16, 17, 18, 23, 28, 29, 30, 31, Jun 4, 6, 8, 2012	2012_064167_0016	Complaint

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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered staff, personal support worker staff, and identified residents related to Complaint Logs #H-000519-12 and #H-000785-12.

During the course of the inspection, the inspector(s) conducted a tour and observed care on the unit where the identified residents reside, reviewed the clinical records for three identified residents, reviewed investigation notes completed by the home, conducted interviews with identified residents where possible and reviewed relevant policies and procedures.

The Dietary Inspector completed a portion of Complaint Inspection # H-000519-12.
One area of non-compliance was found related to the licensee's failure to ensure that each resident has his or her desired bedtime supported and individualized under Ontario Regulation 79/10.
This non-compliance [O.Reg. 79/10 s.41] was issued in inspection #2012_122156_0013 conducted simultaneously with this inspection and is contained in the report of that inspection.

The following Inspection Protocols were used during this inspection:

Personal Support Services

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 O.Reg 79/10, s. 30. General requirements
Specifically failed to comply with the following subsections:

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 did not ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented for resident #002.

The documentation on the resident's health file does not include all actions taken or assessments completed by staff related to the resident's urinary symptoms. Interviews with registered staff revealed that staff sent repeat specimens of urine because a previous laboratory report indicated that there was isolated microflora suggestive of contamination, another laboratory report indicated Haemolytic Streptococci group B, significance of which was questionable and a third indicated Heamolytic Strepococci group B, significance of which was questionable. Two weeks later an order was received from the physician for an antibiotic to treat the resident's urinary tract infection.
A registered staff member interviewed indicated that the physician would not treat the resident without a laboratory report confirming infection. Information related to actions taken and whether the physician was made aware of the results of the laboratory reports or the resident's symptoms was not documented on the resident's health file.

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 all actions taken with respect to a resident under a program, including interventions and resident's responses to interventions are documented., 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 subsections:

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. The licensee did not ensure that the care set out in the plan of care for resident #001 was provided as specified in the plan.

a) The plan of care for the resident related to their responsive behaviours directs staff to document a summary of each episode, note the cause and successful interventions, including frequency and duration, initiate behaviour charting for the resident to identify why they become angry and agitated (note time of day, who was present and what preceded the incident).
b) A review of the resident's health record revealed that staff are documenting the resident's responsive behaviours on a data collection sheet provided by an outside agency. This sheet is a checklist and notes each incident when it occurs but no specifics regarding the incidents, actions taken, duration etc.
Staff did not provide documentation on the resident's health record related to the resident's responsive behaviours as specified in their plan of care.

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 care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The plan of care for resident #003 does not include written strategies including techniques and interventions to prevent, minimize or respond to their responsive behaviours.

a) The progress notes for resident #003 and documentation related to a care conference that was held indicate that the resident has responsive behaviours.
b) The Resident Assessment Protocol for resident #003 confirms that the resident displays these behaviours.
The plan of care for resident #003 does not include written techniques or interventions to prevent, minimize or respond to all of the resident's identified behaviours.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has not ensured that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

a) It was noted during a tour of Cedar Home Area that 16 out of 26 rooms reviewed had call bells that were not equipped with a clip to hold the call bells in place. Consequently in four of the rooms reviewed, the residents' call bells were noted to be laying on the floor and not easily accessed for use.
b) The call bells that were not equipped with a clip were noted to be in rooms 203, 206, 208, 211, 212, 213, 215, 216, 218, 219, 220, 221, 222, 224, 226 and 230.
c) The call bells that were noted to be on the floor were in rooms 218, 219, 222 and 230.

Issued on this 16th day of July, 2012

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