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

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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
Dec 18, 2015	2015_288549_0033	O-002678-15	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

RENA BOWEN (549)

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): December 14, 15, 16, 2015

The following complaints IL-40171-OT, IL-40240-OT and IL-40542-OT were also inspected within the same log number.

During the course of the inspection, the inspector(s) spoke with residents, a Power of Attorney, a Unit Manager, the Nutritional Care Manager, the Director of Strategies and Special Projects, the Director of Operations, the Director of Resident Care and the Chief Executive Officer.
A review of a resident's health care record, e-mail correspondence, written letters of complaints and concerns, Residents' Council meeting minutes, the home's zero tolerance of abuse and complaints policies and the home's investigation documentation related to resident abuse was completed during the inspection.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint which is received by the home concerning the care of a resident or the operation of the home is immediately forwarded to the Director.

The home received a letter of complaint on a specific date in September 2015 concerning how the Residents' Council meeting was conducted on a specific date in August 2015. The letter indicated that the complainant had concerns that the home was interfering with the functioning of the Residents' Council. The letter of complaint also made a request for the disclosure of a Critical Incident Report that was made by the home to the Ministry of Health and Long Term Care. The complainant indicated concerns about the accuracy of the Critical Incident Report.

During an interview with the Chief Executive Office on December 17, 2015 it was confirmed with Inspector #549 that the licensee did not forward the letter of complaint dated September 3, 2015 to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

The home received a letter of complaint on a specific date in September 2015 concerning how a Residents' Council meeting was conducted on a specific date in August 2015. The letter of complaint indicated that the complainant had concerns that the home was interfering with the functioning of the Residents' Council. The letter of complaint also included a request for the disclosure of a Critical Incident Report that was made by the home to the Ministry of Health and Long Term Care. The complainant indicated concerns about the accuracy of the Critical Incident Report.

During an interview with the Chief Executive Officer on December 16, 2015 it was confirmed to Inspector #549 that a response from the licensee addressing the letter of complaint dated September 3, 2015 was not provided to the complainant. [s. 101. (1) 1.]

Issued on this 24th day of December, 2015

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

Original report signed by the inspector.