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
Dec 21, 2015	2015_287548_0029	031627-15, 031628-15, 034601-15	Follow up

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

RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 14, 15 ,16 and 17, 2015

Reviewed the: Abuse policy, Reimbursement policy, Home's investigative notes, health care records, Incident Reports,education and training on the promotion of zero tolerance of abuse, observed staff to resident interaction and resident areas. Included in the inspection was CIR#: 2935-000046-15, Log#: 034601-15.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer, Director of Resident Care, Manager of Quality and Education, Registered Nurses (RNs), Unit Manager, Accounting clerk and Health Care Aides (HCAs).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2015_360111_0011	548
LTCHA, 2007 S.O. 2007, c.8 s. 20.	WN	2015_365194_0022	548
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2015_365194_0022	548
O.Reg 79/10 s. 245.	WN	2015_365194_0022	548
O.Reg 79/10 s. 245.	WN	2015_360111_0011	548
O.Reg 79/10 s. 245.	CO #001	2015_365194_0022	548

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. (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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The home submitted Critical Incident Report (CIR) on a specific day in December, 2015 indicating there was improper use of a mechanical lift for resident #002 on a specific day in December, 2015.

Resident #002 was admitted to the home and due to cognitive decline required assistance from staff members for transferring between surfaces.

The health record was reviewed. The resident #002 had decreased ability to perform self-transfers and required assistance by staff members. The resident's #002 care plan specified how transferring was to be performed.

On December 16, 2015 it was observed by inspector #548 in the resident's bedroom a sign with a picture depicting the appropriate transfer method for resident #002.

Review of the home's investigative notes indicated that on a specific evening in December, 2015 a HCA entered resident's #002 room and observed the resident having care performed by a HCA while standing on a mechanical lift. The HCA reported the observation to RN #108.

On December 17, 2015 during interviews with the RN #108, the unit's manager and Director of Resident Care, all indicated that resident #002 was only to be transferred as specified in the plan of care. [s. 6. (7)]

Issued on this 21st day of December, 2015

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

Original report signed by the inspector.