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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
May 20, 2016	2016_328571_0012	013986-16	Complaint

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 12, 13, and 16, 2016.

The following Logs for were inspected:
#011335-16
#013986-16

In addition, a Critical Incident related to an above log was inspected.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, the Manager of Strategy and Special Projects, Registered Nurse Manager, Registered Charge Nurses , Registered Practical Nurses, Personal Support Workers, a resident and Substitute Decision Maker for that resident.

During the inspection, resident and staff interaction and the resident's environment was observed. In addition, clinical record, emails, Critical Incident Reports and the licensee's policy on immunization were reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours

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. (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 has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Re: Log #013986-16:

In addition to Log #013986-16, a Critical Incident Report (CIR) was also submitted concerning toileting.

A review of the CIR indicated that on a specified date the Substitute Decision Maker (SDM) for resident #005 observed a staff member toilet resident #005 independently.

A review of resident #005's plan of care indicated that the resident is to be assisted with toileting with two staff members present at all times for safety reasons.

A review of the licensee's investigation, indicated that the licensee concluded that PSW #120 did assist resident #005 with toileting without the presence of a second staff member on a specified date.

Therefore, the licensee failed to ensure that toileting was provided to resident #005 with two staff present as specified in the plan of care. [s. 6. (7)]

2. Re: Complaint Log #011335-16:

As per O. Reg. s. 229. (10) 2., each resident must be offered immunization at the appropriate time each year.

The licensee's Policy outlines the procedure for the annual immunization for the residents. This procedure includes a physician order and annual consents.

A review of the clinical records indicated that consent was obtained from resident #005's Substitute Decision Maker (SDM) for administration of the vaccine each year since the resident was admitted to the home. Resident #005 was administered the flu vaccine on the following years:
-2010 administered by Staff #107
-2011 administered by Staff #108
-2012 administered by Staff #108
-2013 administered by Staff #109
-2014 administered by Staff #110

The clinical records indicated that on specified date in November of 2015, Staff #108 attempted to administer the vaccine but the resident refused. The clinical records also

indicated that resident #005 has responsive behaviours including resisting treatment or care. Interventions include re-approaching later; trying to provide care with an alternate staff member and allowing for flexibility in the provision of care to accommodate the resident's moods. No evidence that any other staff member attempted to administer the vaccine on any other date can be found.

On a specified date in December 2015, Charge RN #106 documented that during a telephone conversation, the SDM of resident #005 asked if the resident had received the vaccination. In an interview, RN #106 clarified that he/she knew consent was obtained from the SDM but that resident #005 refused to consent to the vaccination in November of 2015. Charge RN #106 did not attempt to administer the vaccine to resident #005 on that date nor did he/she assign the task to another staff member.

In an email sent to Manager #111 in January of 2016, the SDM of resident #005 asked Manager #111 if resident #005 had the vaccination yet. In an interview, Manager #111 indicated that the email was forwarded to nursing for a response.

In March of 2016, during a care conference, the SDM of resident #005 expressed concern that the resident did not receive the vaccine. The home offered to administer the vaccine that day. The vaccine was administered by RPN #112.

Therefore, despite several inquiries by the SDM, the home failed to ensure resident #005 received the vaccine as specified in the plan of care. [s. 6. (7)]

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 with ensuring that the care set out in resident #005's plan of care is provided as specified in the plan, to be implemented voluntarily.

Issued on this 20th day of May, 2016

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

Original report signed by the inspector.