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 soins 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
Oct 5, 2016	2016_397607_0022	016990-16, 025566-16, 026114-16, 028334-16	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

JULIET MANDERSON-GRAY (607)

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): September 21, 22, 23, 26, 27 & 28, 2016.

During the course of this Critical Incident Inspection, the following intakes were reviewed and inspected upon Log #'s: 016990-16, 025566-16, 026114-16, and 028334-16.

Summary of intakes:

1) #016990-16, Critical Incident Report, regarding a fall resulting transfer to a hospital.
2) #025566-16, Critical Incident Report, regarding resident to resident alleged sexual abuse.
3) #026114-16, Critical Incident Report, regarding resident to resident alleged sexual abuse.
4) #028334-16, Critical Incident Report, regarding a missing or unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with the Director of Operations, the Administrator, the Director of Care (DOC), the Manager of Quality and Education, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of this inspection the inspector reviewed clinical health records, observed staff to resident interactions, reviewed the home's investigation notes (Specific to identified Critical Incident Reports), reviewed home specific policies related to Resident Abuse Prevention, Falls, Responsive Behaviour, Medication management, Restraint, Skin and wound and Continence Management.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **2 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 provided to the resident as specified in the plan.

Re: Critical Incident Log #016990-16 for resident #002:

A Critical Incident Report (CIR) was received by the Director on an identified date for an incident of a fall resulting in a transfer to the hospital that occurred on an identified date at a specific time period. The CIR indicated resident #002 sustained a fall, resulted in injury.

Review of the plan of care for resident #002 indicated the resident was at high risk for falls and had a high Morse Fall Score. Interventions included staff to check every hour to ensure safety, and must be supervised when outside.

Interview with PSW #115 indicated he/she was present when the incident occurred. PSW #115 also indicated he/she had taken the resident outside, then left the resident unattended to go back inside to retrieve his/her sweater and had stopped to speak with the RN, and while speaking with the RN he/she witnessed the resident got up from a chair and fell.

Therefore the plan of care was not followed as resident #002 was left unsupervised, resulting in a fall and injury. [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 to ensure the care set out in the plan of care was provided to the resident as specified in the plan related to fall prevention, specifically related to resident #002, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:

ii. the long-term actions planned to correct the situation and prevent recurrence.

Re: Critical Incident Log #025566-16 for resident #009 and #010:

A Critical Incident Report (CIR) was received by the Director on an identified date for an alleged resident to resident sexual abuse that occurred on an identified date at a specific time period. Resident #009 was witnessed inappropriately holding resident #010's body part.

Review of the Critical Incident Report amended on an identified date failed to indicate what long-term actions/plan the home had put in place to correct the incident involving resident #009 and #010 to prevent further recurrence.

Interview with Home Area Manager #106 confirmed that he/she had forgotten to update the CIR related to the above identified incident.

Therefore the licensee has failed to ensure that the report to the Director included the

long-term actions planned to correct the situation and prevent recurrence, specifically related to resident #009 and #010. [s. 104. (1) 4.]

2. The licensee has failed ensured that a final report was made to the Director within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Re: Critical Incident Log #026114-16 for resident #009 and #010:

A Critical Incident report (CIR) was received by the Director on an identified date for an alleged resident to resident sexual abuse that occurred on an identified date at a specific time period. Resident #009 was witnessed in an area of the home with his/her body part around resident #010's body part.

A review of the CIR and interview with Home Area Manager #106 confirmed that CIR was not amended until 36 days later.

Therefore the licensee has failed ensured that a final report was made to the Director within the time specified by the Director (in 21 days unless otherwise specified by the Director), specifically related to resident #009 and #010. [s. 104. (3)]

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 report to the Director included an analysis and follow-up actions, that includes long-term actions planned to correct a situation and prevent recurrence, and ensuring that a final report was made to the Director within the time specified by the Director (in 21 days unless otherwise specified by the Director), specifically related to resident #009 and #010, to be implemented voluntarily.

Issued on this 5th day of October, 2016

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

Original report signed by the inspector.