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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 25, 2018	2018_670571_0003	019957-17, 020629-17, 024460-17, 025373-17, 025952-17, 027005-17, 029481-17, 029641-17, 000121-18	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

PATRICIA MATA (571)

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): January 30, February 1, 2, 5, 6 and 7, 2018.

The following Critical Incident logs related to abuse were inspected: 019957-17, 020629-17, 000121-18, 024460-17, 025373-17, 025952-17, 027005-17, 029481-17, 029641-17

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Resident Care (DRC), Home Area Managers (HAM), Behavioural Supports Ontario Personal Support worker (BSO PSW), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), residents and family members.

In addition, clinical health records, policies, the licensee's investigation records and employee files were reviewed during this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #006 set out clear directions to staff who provide direct care to the resident.

Re: Log # 019957-17:

A Critical Incident Report (CI) was submitted by the licensee regarding an incident of alleged staff to resident physical abuse occurring on a specified date. Resident #006 was provided assistance with a specified Activity of Daily Living (ADL) by PSW #110 resulting in resident #006 obtaining an identified injury.

A review of the clinical record by Inspector #571 for resident #006 indicated that resident #006 required a specific intervention related to a specified daily ADL's. A review of the progress notes for a specified date, indicated that resident #006 obtained a specified injury while receiving assistance with the specified ADL.

A review of the licensee's investigation package indicated that PSW #110 observed directions related to the assistance with a specified ADL's for resident #006 and performed the intervention. Resident #006's care plan at the time of the incident indicated different directions that required more assistance for the same ADL.

In an interview with Inspector #571 on a specified date, Home Area Manager #103 indicated that on the day of the incident, there were two separate directions for staff in resident #006's plan of care for when staff were assisting with the specified ADL. PSW #110 provided the assistance with the specified ADL to resident #006 based on one set of instructions. During the assistance with the specified ADL by PSW #110, resident #006 was injured. PSW #110 was not disciplined as the licensee determined that the directions were not clear.

In an interview with Inspector #571 on a specified date, PSW #110 indicated that they observed one of the directions for assisting resident #006 with a specified ADL and provided assistance according to that direction. PSW #110 was not aware of the second direction in the care plan that indicated more assistance was required for the specified ADL.

The licensee failed to ensure that the written plan of care for resident #006 set out clear directions to staff. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure steps were taken to minimize the risk of potentially harmful interactions between resident #001 and #002 by identifying and implementing interventions.

Re: Log # 025373-17:

A CI was submitted by the licensee regarding an alleged incident of abuse that occurred on a specified date and at a specified time. The CI indicated that resident #002 was allegedly abused by resident #001 when resident #001 displayed specific responsive behaviours.

A review of the clinical records indicated that resident #001's has a specified diagnosis and means of getting around the home. Resident #001 also had a history of a specified responsive behaviour.

A review of the clinical records indicated that resident #002's had a specified and means of getting around the home.

A review of the progress notes by Inspector #571 for a specified date indicated that resident #002 was sitting in a chair in the resident's room. A nurse observed resident #001 displaying the specified responsive behaviour toward resident #002. The residents

were separated. Resident #001 was closely monitored by staff until more heightened monitoring was implemented for an additional four hours on the same day.

A review of the plan of care for resident #001 indicated additional interventions were implemented for the resident's identified responsive behaviour.

After review of resident #002's plan of care by Inspector #571, interventions related to keeping resident #002 safe from resident #001's identified responsive behaviour could not be found.

In an interview with Inspector #571 on a specified date, BSO PSW #104 indicated they were unable to locate evidence of interventions implemented to keep resident #002 safe from resident #001's identified responsive behaviour.

In an interview with Inspector #571 on a specified date, PSW #105 indicated that resident #001 has never displayed the specified responsive behaviour on their shift. PSW #105 indicated that the interventions to keep all residents safe from any resident that may be demonstrating the specified responsive behaviour was that staff always monitor all residents for the identified responsive behaviour and would separate residents if the behaviour was occurring. [s. 54. (b)]

Issued on this 26th day of April, 2018

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

Original report signed by the inspector.