Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 12, 2019	2019_617148_0020	031809-18, 032814-18, 002400-19	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

AMANDA NIXON (148), LISA KLUKE (547)

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): June 24, 25, 26 and 27, 2019

This inspection included three critical incident reports (CIR): CIR #2935-000044-18 (Log 032814-18) and CIR #2935-000002-19 (Log 002400-19) both related to falls that caused injury whereby a resident was taken to hospital and which resulted in significant change in health status; and CIR #2935-000042-18 (Log 031809-18) related to alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Manager of Professional Improvement, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition the Inspectors reviewed resident health care records, observed the resident care environment, resident to resident and staff to resident interactions and resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The plan of care for resident #002 identified the resident at risk for falls. The resident had a fall resulting in an injury on a specified date. As part of the restraint plan of care, the resident was to be provided with physical devices as a restraint.

The resident was observed on the morning of June 25, 2019, with physical devices in place, one of which was not applied. PSW #112 who was present during the observation, applied the device noting that the resident was known to spontaneously release the device. Additionally, the PSW reported that the resident pushes and pulls on the device causing it to loosen or release. On a subsequent observation in the afternoon the device was applied and was observed to be loose.

The Inspector reported the observation of the loose device to both PSW #112 and RPN #111. The staff took no action to correct the device and reported that the resident will loosen the device regularly. In discussion, RPN #111 indicated that the physical restraint was signed for on each shift and that the purpose of this sign off was to acknowledge the device was applied and in use. The RPN indicated that if the resident was in an alternative position that it was likely the device was not needed. The RPN did not identify a safety concern with the resident's behaviour to loosen the device. Neither staff member were aware of the resident's care planned need for a cover on the device, which was not

observed to be applied.

In discussion with the Manager of Professional Improvement #101, it was indicated that the identified device should fit snug to the resident without excessive slack. Manager #101 was not aware of the resident's current behaviours related to the device and when asked it could not be established that the use of the device had been re-assessed since the implementation.

The care set out in the plan of care was not based on the current needs of resident #002 with regards to the use and application of physical devices used as a restraint.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care indicted that resident #002 required four devices in place to prevent falls and/or injury from falls, including physical devices for restraining.

As described above resident #002 was observed on June 25, 2019. During the first observation the resident did not have three of the care planned devices in place and/or applied. At the time of the observation, staff could not find one of the devices, the other was reported to no longer be in use and staff were not aware of the need for the third device.

During observations of June 25, 2019, resident #002 did not have care provided as specified by the plan related to fall risk.

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented, specifically as it relates to hourly safety monitoring.

The plan of care for resident #002 described that at the time of a specified fall, and at present, resident #002 requires hourly monitoring for safety. Staff reported that hourly monitoring of the resident is conducted by the PSW staff members and would be documented in the electronic record. A review of the health care record and documentation completed by staff in the electronic record (Point of Care), demonstrated that hourly monitoring was not documented for a period related to the identified fall. In addition, documentation for the month of June 2019 was reviewed and did not include

documentation of hourly safety checks for resident #002.

(Log 002400-19) [s. 6. (2)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application and all repositioning.

In accordance with section 110 (2) of O. Regulation 79/10, where there is use of a physical device to restrain a resident under section 31 of the LTCHA, the resident is released from the physical device and repositioned at least once every two hours.

As described by written notification #1, resident #002 was observed with a physical device applied as a physical restraint.

The Inspector reviewed the required documentation related to the device for June 22, 23, 24 and 25, 2019. The following deficiencies were noted:
On June 22, 2019, there was no documentation to indicate the time the device was applied along with a nine hour time period with no recorded release or repositioning;
On June 23, 2019, there was no documentation to indicate the time the device was applied along with an eight hour time period with no recorded release or repositioning;
On June 24, 2019, there was a five hour time period with no recorded release or repositioning; and
On June 25, 2019, there was a four hour time period with no recorded release or repositioning.

(Log 002400-19) [s. 110. (7) 5.]

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.