Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 18, 2022	2022_815623_0004	021208-21, 004142-22	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

SARAH GILLIS (623)

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): March 29, 30, 31 and April 1, 2022

The following intakes were inspected concurrently:
A complaint related to medications, falls and vaccinations.
A complaint related to access to the home.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), the Manager of Professional Practice, Home Area Managers (HAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, residents and families.

The Inspector also reviewed the licensee's internal records, resident health care records, related policies, observed housekeeping services, observed Infection Prevention and Control practices, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

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)**

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director which indicated that resident #001 had received a specific medication late on five identified dates. The resident was prescribed a specific medication for Parkinson’s disease and was to receive the medication at prescribed times.

Review of resident #001’s medication administration records which included the time stamp for administration on the specified dates was completed. On two of the five identified dates, it was verified the medication was documented as administered greater than one hour following the prescribed time. Review of the licensee’s medication incident reports indicated one additional date where the nurse reported late administration. This date was not included in the information received from the complainant, the medication incident report indicated the SDM had been notified.

Interviews with Registered Staff and the Nursing Management revealed the expectation of the home was medications are to be administered as close to the prescribed time as possible. When unforeseen circumstances do not allow for this, safe and consistent spacing of medications that are prescribed more than once daily is the expectation of the home.

When resident #001 received their specific identified medication greater then one hour past the prescribed time, the resident was at risk for increased disease specific symptoms.

Sources: Resident #001’s eMAR, medication incident report, physician orders, CNO Standards for Medication Administration, related policies, interviews with Registered staff and Management. [s. 131. (2)]

Issued on this 18th day of May, 2022

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

Original report signed by the inspector.