Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
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Original Public Report

Report Issue Date: April 5th, 2023
Inspection Number: 2023-1419-0002
Inspection Type: Complaint Follow up Critical Incident System
Licensee: St. Joseph's at Fleming
Long Term Care Home and City: St. Joseph's at Fleming, Peterborough

Lead Inspector	**Inspector Digital Signature**
Najat Mahmoud (741773)	
Additional Inspector(s) Catherine Ochnik (704957) Nicole Jarvis (741831) Rita Lajoie (741754)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):

March 2, 3, 6 to 10, and 13 to 16, 2023

The following intake(s) were inspected:

- Compliance Order (CO) #001, O. Reg 79/10 s. 229 (4) related to infection prevention and control (IPAC) with a Compliance Due Date (CDD) of March 31, 2022
- CO #001, FTCA, 2021 s. 6(7) related to plan of care with a CDD of January 30, 2023
- CO #002, O. Reg 79/10, s. 36 related to transferring and positioning techniques with a CDD of January 30, 2023
- CO #003, O. Reg 246/22 s. 53(1)1 related to falls prevention and management program with a CDD of January 30, 2023

- CO #004, O. Reg 246/22 s. 102(9)(a) related to IPAC with a CDD of January 30, 2023
- CO #005, O. Reg 246/22 s. 102(2)(b) and IPAC Standards 10.4 (h) related to resident hand hygiene before meals with a CDD of January 30, 2023
- CO #006, O. Reg 246/22 s. 272 related to IPAC with a CDD of January 30, 2023
- CO #007, O. Reg 246/22 s. 58(4)(b) related to responsive behaviors with a CDD of January 30, 2023
- CO #008, O. Reg 246/22 s. 140(2) related to administration of drugs with a CDD of January 30, 2023
- CO #009, FLTCA, 2021 s. 24(1) related to duty to protect with a CDD of January 30, 2023
- CO #010, FLTCA, 2021 s.11(1)(a) related to nursing and personal support services with a CDD of January 30, 2023
- CO #011, FLTCA, 2021 s. 11(1)(b) related to nursing and personal support services with a CDD of January 30, 2023
- CO #012, O. Reg 246/22 s. 102(8) related IPAC with a CDD of January 30, 2023
- A Critical Incident related to falls prevention and management program.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
O. Reg 79/10 s. 229. (4), from Inspection #2021-885601-0024, CO #001, inspected by Catherine Ochnik (704957)

FTCA, 2021 s. 6(7), from Inspection #2022-1419-0001, CO #001, inspected by Najat Mahmoud (741773)

O. Reg 79/10, s. 36, from Inspection #2022-1419-0001 CO #002, inspected by Najat Mahmoud (741773)

O. Reg 246/22 s. 53(1)1, from Inspection #2022-1419-0001, CO #003 inspected by Najat Mahmoud (741773)

O. Reg 246/22 s. 102(2)(b), and IPAC Standard 10.4 (h), from Inspection #2022-1419-0001, CO #005, inspected by Rita Lajoie (741754)

O. Reg 246/22 s. 272, from Inspection #2022-1419-0001, CO #006, inspected by Catherine Ochnik (704957)

O. Reg 246/22 s. 58(4)(b), CO #007 from Inspection #2022-1419-0001, CO #007, inspected by Najat Mahmoud (741773)

O. Reg 246/22 s. 140(2), from Inspection #2022-1419-0001, CO #008, inspected by Nicole Jarvis (741831)

FLTCA, 2021 s.11(1)(a), from Inspection #2022-1419-0001, CO #010, inspected by Nicole Jarvis (741831)

FLTCA, 2021 s. 11(1)(b), from Inspection #2022-1419-0001, CO #011, inspected by Nicole Jarvis (741831)

O. Reg 246/22 s. 102(8), from Inspection #2022-1419-0001, CO #012, inspected by Catherine Ochnik (704957)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

O. Reg 246/22 s. 102(9)(a), from Inspection #2022-1419-0001, CO #004, inspected by Rita Lajoie (741754)

FLTCA, 2021 s. 24(1), from Inspection #2022-1419-0001, CO #009, inspected by Nicole Jarvis (741831)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: CONDITIONS OF LICENSE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #004 from Inspection #2022-1419-0001

related to the O. Reg. 246/22 s. 102 (9) (a) monitoring of symptoms indicating the presence of infection on every shift with a compliance due date of January 30, 2023.

Specifically, the licensee must:

1) Develop and implement a process for monitoring residents' with symptoms indicating the presence of infection and include where the symptoms of infection will be documented on every shift. The process will identify who is responsible to assess the resident, and the immediate action to be taken when a resident has a symptom indicating the presence of infection.

2) Keep a documented record of all actions taken when a resident symptom indicates the presence of infection.

3) Educate the PSWs and registered staff on the process to follow to monitor residents with symptoms of infection and what needs to be monitored when an order/recommendation is received by the physician to treat the resident's infection.

4) Keep a documented record of the education provided and staff attendance.

5) Conduct weekly audits on the monitoring process of residents with symptoms indicating the presence of infection, including accurately documenting the resident's symptoms of infection on every shift.

6) Keep a documented record of the audits completed.

Rationale and Summary

During this follow up inspection the home failed to provide accurate documentation to support the compliance order (CO).

Interviews with the Infection Prevention and Control (IPAC) lead and the Director of Resident Care (DORC) confirmed that a process for monitoring residents with symptoms indicating the presence of an illness had not been developed or implemented. The IPAC lead confirmed that enhanced symptom screening (ESS) is to be completed each shift when a resident is receiving treatment for an illness. During interviews RPN and PSW confirmed there was no written process in place for monitoring residents with symptoms indicating the presence of an illness. The IPAC lead and the DORC both confirmed that none of the requirements of the order had been implemented.

A review of two resident's clinical records indicated they were receiving a treatment for an illness and the symptoms were not being recorded on every shift during this period.

When the licensee failed to develop and implement a process for monitoring residents with symptoms indicating an illness, failed to educate staff on this process and failed to audit the process, it increased the risk that signs of illness may not be identified or may limit determination if treatment for an identified illness was effective.

Sources: Review of resident's clinical records, review of orientation training for PSWs; interviews with RPN, PSW, IPAC lead and the DORC.

[741754]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Compliance Order #004 issued in Inspection #2022-1419-0001, on November 3, 2022, with a compliance due date of January 30, 2023, related to O. Reg 246/22 s. 102 (9)(a).

This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: CONDITIONS OF LICENSE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #009 from Inspection #2022-1419-0001 regarding O. Reg 246/22 s. 24 (1) served on November 3, 2022, with a compliance due date of January 30, 2022.

Specifically, the licensee must:

1) Re educate an RN on the home's Prevention of Abuse policy, specifically the reporting timeline for abuse.

2) Re educate a PSW on the home's Prevention of Abuse policy, specifically neglect of care.

3) Ensure that RN and PSW complete the Zero Tolerance of Abuse education on Surge Learning.

4) Develop and implement a tracking method to ensure that all staff are provided with abuse education annually.

5) Review a resident's responsive behaviours, triggers and revise their plan of care to include interventions that will reduce the risk of responsive behaviours.

6) Ensure that when utilizing the Dementia Observation System (DOS) tool, for a resident, documentation of the interventions must be completed.

7) Educate staff providing direct care to a resident on implementing immediate interventions, including when, how and who completes and evaluates the DOS tool.

8) Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

Rationale and Summary

A review of a resident's clinical record for a specific time period indicated that there were multiple missing entries with the DOS tool.

The required education to staff providing direct care to the resident was incomplete and not provided to all the staff.

The licensee was unable to provide a documented record of the education content which identified the individual who provided the education, those who attended, and the date of the training on when, how and who completes and evaluates the clinical record.

Sources: Interviews with Home Area Manager, PSW, and RPN; review of clinical records of resident;

review of the licensee's evidence.

[741831]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Compliance Order #009, issued in Inspection #2022-1419-0001, on November 3, 2022, with a compliance due date of January 30, 2023, related to O. Reg 246/22 s. 24 (1)

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
1**) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.4.**

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes,

dated April 2022 (IPAC Standard), section 10.4 states, the licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as: h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary

Observations were made on a resident home area (RHA) during the snack distribution. A PSW did not support the resident with hand hygiene prior to providing them with a snack.

The PSW stated that the expectation was to offer the resident hand sanitizer and expressed that they forgot to do it.

The IPAC lead stated there were hand sanitizer dispensers on the snack cart and that all residents have hand sanitizer in their room to use prior to receiving a snack. The IPAC lead identified the need of reeducation for the staff on this requirement.

The licensee failed to ensure the residents were provided the support with hand hygiene prior to receiving a snack which increased the risk of spreading infection.

Sources: Observations, interviews with PSW, IPAC Lead.

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2) Non-compliance with O. Reg. 246/22 s. 102 (2)(b), IPAC Standard section 9.1 (b)
The licensee failed to implement any standard or protocols with the donning of Personal Protective Equipment (PPE) as issued by the Director with respect to infection prevention and control.

Rationale and Summary

The licensee has failed to ensure that routine practices and additional precautions were followed in the Infection Prevention and Control program in accordance with the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes (IPAC Standard). Specifically, in accordance with section 9.1 (d) of the IPAC Standards for LTCH's, dated April 2022, the licensee shall ensure that routine practices were followed in the IPAC program, including the proper use of Personal Protective Equipment (PPE).

The Care Support Aide (CSA) was observed not wearing the appropriate PPE when interacting with two residents inside a shared room that required additional precautions. The CSA had physical contact with the resident in their room.

The CSA acknowledged that the room required additional precautions to be taken and confirmed that they had entered the room without donning the required PPE.

The Charge Nurse confirmed that the resident was on additional precautions for an illness and stated that the expectation of all individuals entering the room was to don the appropriate PPE.

Failure to wear the appropriate PPE at the point of care increased the risk of transmission of infectious disease.

Sources: Observations, and Interviews with staff.

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