Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 29, Mar 1, 7, 8, 9, 16, 2012	2012_043157_0008	Critical Incident

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
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 POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Nursing Care Coordinator, Nursing Unit Manager, one RPN, the home's Manager of Human Resources and one identified resident.

During the course of the inspection, the inspector(s) conducted critical incident inspections related to three reported incidents, reviewed the clinical health records related to the residents involved, reviewed the home's investigation records for the identified incidents, reviewed the home's policies and procedures related to Pain Management, Bathing, Zero Tolerance for Abuse and Neglect, Complaint Management, Falls Prevention and Management.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The home reported that an identified resident experienced a fall resulting in an injury. Progress notes in the resident's clinical record indicate that the resident was experiencing pain as a result of the injury. The resident's plan of care was not based on an assessment of the resident's pain management needs and does not provide any pain management interventions related to the above noted injury.[s.6.(2)]
2. An identified resident was noted to have an injury. This injury and required interventions were not identified on the resident's plan of care and there was no indication of any assessment of the cause of the injury. There was no indication of a medical assessment to determine the needs of the resident related to the physical characteristics and pain associated with the injury.[s.6.(2)]
3. The plan of care for an identified resident was not revised to reflect the change in care needs related to two injuries. [s.6(10)(b)]
4. The plan of care for an identified resident did not provide any direction to staff for the management of the resident's pain.[s.6(1)(c)]

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 resident plans of care are reviewed and revised when resident care needs change and provide clear direction for interventions required for pain management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. An allegation of abuse of an identified resident was not reported to the Director until a Critical Incident Report was submitted 9 days later.
2. An allegation of abuse of an identified resident was not reported to the Director until a Critical Incident Report was submitted 3 days later.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. There is no evidence that the results of the investigation of an incident involving the abuse of resident were reported to the Director.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Staff confirmed that an identified resident would have difficulty accurately communicating that he/she was experiencing pain. Clinical progress notes indicate that the resident was experiencing pain as a result of an injury. There is no evidence that a clinically appropriate assessment instrument was used to assess the resident's pain and determine appropriate interventions. [r.52(2)]
2. Clinical progress notes indicate that an identified resident had an injury and was experiencing pain as a result of that injury. There is no evidence that a clinically appropriate assessment instrument was used to assess the resident's pain and determine appropriate interventions. [r.52(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 residents experiencing pain which is not relieved by initial interventions are assessed using a clinically appropriate assessment instrument to determine pain management interventions required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. As required by O.Reg.79/10,s.52. the home has a pain management program in place (Policy - Pain Management Program - Policy No. 8-145, last review September, 2011). The home's policy was not complied with as evidenced by the following related to a Critical Incident reporting a resident's injury:
- the resident's level of pain was not assessed and ranked from 1-10
- there is no evidence that the home collaborated with the resident/POA when the resident experienced a change in health status and pain was not relieved by initial interventions
- there were no strategies implemented to effectively manage the resident's pain including pharmacological and non pharmacological interventions
- the prescribed pain measurement/assessment tools provided in the policy were not implemented for the resident.[r.8 (1)(b)]

Issued on this 16th day of March, 2012

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