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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 10, 2013	2013_184124_0011	O-000528-13	Complaint

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

LYNDA HAMILTON (124)

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): July 4, 5, 2013

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care, Unit Managers, Registered Nurses, Registered Practical Nurses, Health Care Aids/Personal Support Workers and housekeeping staff.

During the course of the inspection, the inspector(s) completed walk through of all home areas, observed staff-resident interactions, made general resident observations, reviewed resident health records, the home's abuse policy and the Abuse Free Care Education package.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, s.20. (1) in that a staff member did not comply with the home's zero tolerance of abuse and neglect policy.

The home's policy,"Abuse and Neglect (Resident)-Zero Tolerance #14-18" stated:

"Physical Abuse means, subject to subsection (2),(a) use of physical force by anyone other than a resident that causes physical injury or pain", and under

"Actions to be Taken by Staff" that staff are to:
1b) report any witnessed, suspected or alleged abuse to a charge nurse, supervisor/manager, director, CEO, or Board Chair, immediately and

1c) document details of the alleged abuse as soon as possible. For those with access to Risk Management Incident Report in Point Click Care (PCC) complete the report with facts.

On a specified date, there is an entry in the progress notes by the Registered Practical Nurse(RPN)#100 describing Resident #1's report that Personal Support Worker (PSW) #107 had intentionally hit the resident with an assistive device during the delivery of care.

Four days later, RPN #100 documented that Resident #1 had an injury at the site where the resident described being hit and RPN#100 questioned if this was a result of the assistive device hitting Resident#1 four days earlier.

During an interview with RPN #100 on July 4,2013, RPN #100 advised inspector 124 that four days after the resident reported the incident, RPN#100 may have verbally reported Resident #1's injury to the charge nurse but did not report the resident's earlier allegation. RPN #100 also stated that although there was access to Point Click Care, a risk management incident report, the home's internal document was not completed.

When RPN#100 was asked if there would be a different response to the situation now, RPN#100 stated that he/she would have notified the charge nurse, completed a risk management incident report and notified the family. He/she attributed the change in action to the change in the home's policy.

1. The licensee failed to comply with LTCHA 2007, s.20. (1) in that a staff member did

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 staff understand and comply with the home's abuse policy, 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:

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. 2007, c. 8, ss. 24 (1), 195 (2).
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. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
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. A person had reasonable grounds to suspect that abuse of a resident had occurred and did not immediately report the suspicion and the information upon which it was based to the Director.

The applicable definition of physical abuse in O.Reg. 79/10 of the LTCHA is "the use of physical force by anyone other than a resident that causes physical injury or pain."

On a specific date, there is an entry in the progress notes by the Registered Practical Nurse (RPN) #100 describing Resident #1's report that Personal Support Worker (PSW) #107 had intentionally hit the resident with an assistive device during the delivery of care.

Four days later, RPN #100 documented that Resident #1 had an injury at the site where the resident described being hit and RPN#100 questioned if this was a result of the assistive device hitting Resident#1 four days earlier.

During an interview with RPN #100 on July 4,2013, RPN #100 advised inspector 124 that four days after the resident reported the incident, RPN#100 may have verbally reported Resident #1's injury to the charge nurse but did not report the resident's earlier allegation because RPN#100 did not consider this abuse.

No Critical Incident Report reporting alleged abuse of this resident was found during a review of the home's Critical Incident Reports for 2013.

PSW#107 is currently not working at the home.

LTCHA 2007, s. 24. (1) was issued as a Compliance Order on June 14, 2013 as part of inspection 2013_031194_0015 and had a compliance date of June 30, 2013. [s. 24. (1)]

Issued on this 10th day of July, 2013

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

L Hamilton