



**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**

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, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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

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 25, 2013	2013_198117_0015	O-000487- 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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection



**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**

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16, 17, 18 and 19, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Unit Managers, Pharmacist, Social Worker, Registered Dietitian, Pastoral Care Coordinator, Resident Program Manager, Coordinator for Nursing Schedule and Education, Registered Nurse, several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), and a family member.

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record, reviewed a unit's mobility equipment report log, reviewed the home's 2013 Staff Education Calendar, reviewed the Minutes of the Health Advisory Committee Meeting of April 17, 2013, reviewed the following policies: Skin and Wound Care Management Program # 8-219, Skin and Wound Management Team - Statement of Purpose and Principle Functions # 8-220, Medical Directive- Bowel Care #8-92, Continence Care - Bladder and Bowel # 8-80, Palliative Care - End of Life #8-158, Palliative Care Program #8-160, Oxygen Therapy - Short and Long Term # 8-134, Pain Management Program #8-145, Private Care Providers #8-178 and Contract Workers for St-Joseph's at Fleming and Contractors Facility Orientation #9-27.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Hospitalization and Death

Medication

Pain

Personal Support Services

Quality Improvement

Reporting and Complaints

Skin and Wound Care

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
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (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; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :



1. The licensee failed to comply with the LTCHA 2007, S.O.2007, C.8. s.6 (10) b in that Resident #1 was not reassessed and the plan of care reviewed when the resident's care needs change.

Resident #1 has cognitive impairments, is incontinent and requires total assistance for all of his/her activities of daily living. The resident's health care record identifies that he/she has a history urinary tract infections(UTI).

On a specific day in May 2013, Resident #1's family member reported to the evening RPN that the resident's urine had a foul smell and expressed concerns that the resident might have a urinary tract infection (UTI). The RPN assessed the resident. Progress notes indicate that the resident's temperature was 36.6 Celsius and that nursing staff would monitor the resident for signs of a UTI.

Progress notes documented that two days later, during the evening shift, Resident #1's family member expressed concerns regarding the resident's health to the unit RPN. The family member reported that the resident's urine had a foul smell and that the resident was not himself/herself. The RPN assessed the resident. The resident had a temperature of 37.7 Celsius. The family member refused administration of an antipyretic medication for the fever. RPN applied a pedibag to try to obtain a urine sample.

A urine sample was obtained a few hours later during the night shift in June 2013 and dipstick urine test was positive for leukocytes, nitrates, protein and blood. The charge nurse was informed and note left for the physician to be contacted in the morning regarding resident's change in health status.

Progress notes document that during the morning of the specified day in June 2013, Resident #1 was assessed by his/her attending physician. He/She was diagnosed with a UTI and prescribed an antibiotic treatment.

On July 18, 2013, interviewed staff members #112, # 114 and #121 stated that they but could not recall receiving information to monitor the resident for possible signs and symptoms of a UTI between the specified days in May and June 2013. There is no documented evidence in Resident #1's Health care record progress notes and 24-hour nursing communication book that the resident was assessed and monitored for signs of a UTI on two specified days in May 2013. [s. 6. (10) (b)]



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

Issued on this 25th day of July, 2013

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

Lynne Dochow #117