Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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_031194_0018	O-000457-13	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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

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

This was a complaint inspection Log # O-000457-13

During the course of the inspection, the inspector(s) spoke with Chief Executive Office (CEO), prior CEO, Director of Care (DOC), 2 Unit Managers (UM), Human Resources, Environmental Service Manager (ESM),Resident and Family Service Manager, Psycho geriatric Nurse, Registered Nurse, Co ordinator of Nursing Services, 1 housekeeping staff, 1 recreational aide, Behavioural Support Ontario (BSO) staff, 1 resident and Substitute Decision Maker (SDM) for a resident

During the course of the inspection, the inspector(s) Reviewed the following processes;complaint,care conference,staffing deployment, deep cleaning process, reviewed 11 resident clinical health records, Resident Council Meeting Minutes, observations of all rooms on the woodland E & F units and interaction of staff in the provision of care to residents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6(4)(a) when resident #8 identified a need for a fall prevention device and the staff did not collaborate with each other to address the request.

Resident #8 stated to inspector a fear of falling during transfers. Resident#8 has been identified to be at risk for falls in the plan of care.

Resident #8 stated that discussions with the licensee's Resident and Family Service Manager, UM#100 and DOC had been initiated related to the request for the fall prevention device. Resident #8 was told that the fall prevention device would be implemented however was not in place at the time of the inspection three months later.

UM #100 stated being aware of the request and that the issue had been taken to the DOC. UM #100 states that the Environmental Service Manager (ESM) and Physio Therapist (PT) were to assess the need for the fall prevention device. UM #100 stated concerns had been brought forward by ESM related to the resident's request.

Physio Therapist(PT) confirmed having a discussion with resident #8, completing an assessment of the residents needs for the fall prevention device and a work order to the ESM for this request. PT stated the device would be beneficial to resident#8's independence.

Staff #109 Co-ordinator of Resident and Family services confirmed being approached by resident #8 to discuss the fall prevention device. Staff #109 stated that PT and ESM were assessing the situation and that a decision was to be made.

The clinical health record for resident #8 indicate that;
-During the admission care conference resident #8 identified the need for the fall prevention device.
-The progress notes for resident # 8 state that the resident had twice asked to have the fall prevention device

DOC confirmed to inspector that the fall prevention device would be applied and resident would be informed.

The staff did not collaborate with each other on this issue so that the residents safety

concerns could be addressed. [s. 6. (4) (a)]

2. LTCHA 2007 s. 6(7) was issued as a Compliance Order on June 20, 2013 under inspection # 2013_196157_0016 with a compliance date of August 05, 2013

The licensee failed to comply with LTCHA 2007, s.6(7) when the planned interventions for resident #7 were not implemented as specified in the plan.

-A "special conference" was held with resident#7's POA to discuss concerns related to the resident's care. During this conference, lighting in the resident's room was discussed. It is noted in the resident's clinical heath record that, softer lighting was to be trialed in the over-bed lighting fixture and ESM was to look into different colors of fluorescent lighting. It was also noted there was a "need to mark on the light plate which toggle turns on over bed lighting system." This identification on the light switch was to avoid the bright light being turned on, when staff entered the room at night to provide care.
-A follow up letter received by POA post conference, indicated the soft light would be used until receipt of a soft coloured blue light and that the over bed light switch had been marked.
-During an interview prior to inspection, POA stated blue lights had not been installed for the over-bed light in the room and that the light switch in the resident's room did not identify which switch was for the over-bed light as discussed in the meeting with the home.
- Observation of resident#7's room was completed by inspector. No coloured lighting was noted over the bed, and the light switch in the resident's bedroom does not indicate which switch is for the over-bed light approximately one month later.
-Inspector was informed by DOC that the blue lighting was not available immediately and the DOC's understanding was that POA was "pleased enough with the soft light." Inspector was informed that a care conference was scheduled for next week and this topic would be reviewed.

The plan of care for resident #7 directs staff to:
-have yellow band on doorway to prevent wanderers from entering room.
BSO and PSW have confirmed with inspector that the yellow banner is still being placed in the resident's doorway for wanderers.
-video clips provided by POA #OCM6U3J2 and #OCM6U4J2 shows a resident wandering into resident #7 room with no yellow band across the doorway. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 31(3)(e) when the staffing plan for the home was not annually evaluated.

Staff# 114 Co-ordinator of Nursing Services was unaware if an evaluation of the staffing plan had been completed.

DOC confirmed there was no documented evidence that would support the staffing plan for the home had been evaluated annually. [s. 31. (3) (e)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with s.53(4)(a)(b)(c) when behavioural triggers, strategies and interventions were not identified for resident #9

O.Reg s. 53 (4) was issued as a Compliance Order on June 20, 2013 under inspection # 2013_196157_0016 with a compliance date of August 05, 2013.

The clinical health record for resident #9 was reviewed for a two week period, it was noted that;
- Resident #9 was pushed by a co-resident causing resident #9 to fall and sustain an injury.
- Resident #9 was grabbed by another co-resident when walking by, with no injuries.
- Resident #9 grabbed out and pulled at a co-resident's walker, then yelling at co-resident to give back the walker. The residents were separated, no injury.
- Resident #9 was going into co-residents' rooms, becoming agitated when staff attempt to redirect.
- Resident #9 was wandering and removing items from other residents rooms. Resident #9 was resistant when items removed by staff to give back to correct owner.
- Resident#9 was wandering into co-residents' rooms, attempting to open windows, exit seeking ++ and getting into the face of co-residents. Resident#9 was getting agitated and aggressive when redirected by staff.

BSO documentation notes for resident #9 during the same two week period state:
- Resident#9 was ramming the wheelchair into co-residents and objects, with no injuries noted.
- Resident #9 was going into co-resident's rooms, BSO staff were constantly re-directing resident #9 to the point of aggression. A co-resident became upset with resident #9 going near co-residents' room, and was verbally threatening resident #9
- BSO staff was constantly re-directing resident #9.
- BSO staff shadowed resident#9 to make sure that resident wouldn't remove items from co-residents' rooms. BSO staff tried unsuccessfully to re-direct resident #9
- BSO staff tried unsuccessfully to re-direct resident#9 from several rooms. Resident #9 became agitated at the intervention.

Behavioural Support Ontario (BSO) staff stated that co-residents have been identified, for being a risk for altercation with resident #9. The plan of care for resident #9 does not have interventions/strategies implemented to minimize this risk. The current plan of care for responsive behaviours for resident #9 does not identify triggers or

interventions for resident #9's aggression towards co-residents. The plan of care does not provide interventions/strategies for the behaviours such as, taking items from co-resident's rooms, agitation and aggression when being redirected. The documentation confirms that resident #9 behaviours will escalate in the early evening however there is no strategy for focused monitoring for this identified time frame.

Issued on this 26th day of July, 2013

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

Chantal Lafreniere (194)