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

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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 23, 2014	2014_195166_0019	O-000475-14	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

CAROLINE TOMPKINS (166)

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): June 16, 17, 18, 2014.

During the course of the inspection, the inspector(s) spoke with Registered staff, Personal Support Worker (PSW), Director of Care (DOC), Unit Manager and the Administrator.

During the course of the inspection, the inspector(s) observed Resident #2 and Resident #3, observed staff to resident interactions and reviewed clinical health records.

The following Inspection Protocols were used during this inspection:

Personal Support Services
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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Log O-000475-14
An anonymous complaint was received indicating that on a identified date and time, Resident #3 was found lying on Resident #2's bed.
Review of the clinical documentation, information in the licensee's incident report and interviews with the DOC, Registered nursing and PSW staff indicated:
A PSW entered the Resident #2's room and found Resident #3 lying on top of the bed and on top of the covers. Resident #2 was lying in the bed and was under the covers. Both residents were fully clothed and appeared to be unaware of each other.
The PSW informed Resident #3 that it was not their room and assisted the resident off the bed and redirected the resident out of Resident #2's room. Resident #2 appeared calm and unaffected by the incident.

Interview with Registered nursing staff and PSW staff in the resident's home area indicated Resident #3 does display responsive behaviours and the Behaviourial Support Team Ontario(BSO) is following the resident.
Interview with the Director of Care and the Unit Manager indicated Resident #3 was not aware of being in the wrong room nor was Resident #3 aware another resident was lying in the bed.

Review of the plan of care for Resident #3 does not indicate the resident has responsive behaviours related to wandering into other residents' rooms.

The licensee failed to ensure the plan of care for Resident #3 set out clear directions to staff and others who provide direct care to the resident on how to mitigate/ manage Resident #3's wandering into other residents' rooms within the home area [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 the written plan of care for Resident #3 sets out clear direction to staff and others on how to mitigate/ manage the resident's behaviour of wandering into other resident's rooms., to be implemented voluntarily.

Issued on this 24th day of July, 2014

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