



**Ministry of Health and Long-Term Care**

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**

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

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<b>Inspection Report under the LTC Homes Act, 2007</b> <input checked="" type="checkbox"/> Public Copy <input type="checkbox"/> Licensee Copy		<b>Rapport d'inspection prévue de la Loi de 2007 les foyers de soins de longue durée</b> <input type="checkbox"/> Copie du Titulaire <input checked="" type="checkbox"/> Copie de la Publique	
<b>Date(s) of inspection/Date de l'inspection</b> August 5, 2010		<b>Inspection No/ d'inspection</b> 2010_146_2975_Aug1 23212 H - 00011	<b>Type of Inspection/Genre d'inspection</b> Critical Incident C566-000017-10
<b>Licensee/Titulaire</b> St Joseph Health System, 56 Governor's Road, Dundas, L9H 5G7			
<b>Long-Term Care Home/Foyer de soins de longue durée</b> St Joseph's Villa, 56 Governor's Road, Dundas, L9H 5G7			
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b> Barbara Naykalyk-Hunt, LTC Homes Inspector – Nursing #146			
<b>Inspection Summary/Sommaire d'inspection</b>			
<p>The purpose of this inspection was to conduct a Critical Incident inspection related to a resident who fell and passed away in hospital.</p> <p>The inspection was conducted by the above named inspector.</p> <p>The inspection occurred on August 5, 2010.</p> <p>During the course of the inspection, the inspector(s) spoke with: Nurse manager in charge of Home, Acting Director of Care, administrative assistant.</p> <p>The following Inspection Protocols were used in part or in whole during this inspection: Falls prevention During the course of this inspection a review of the resident's health record was conducted.</p> <p>1 Findings of Non-Compliance was found during this inspection. The following action was taken: 1 WN</p>			

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

### NON- COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

**WN** – Written Notifications/Avis écrit  
**VPC** – Plan of correction/Plan de redressement  
**DR** – Director Referral/Régisseur envoyé  
**CO** – Compliance Order/Ordres de conformité  
**WAO** – Work and Activity Order/Ordres: travaux et activités

#### **WN#1: The Licensee has failed to comply with: The Nursing Homes Act, RSO 1990 chap.N.7, s. 20.10 (a) (c) (d)**

A licensee of a nursing home shall ensure that;

- (a) the requirements of each resident of the nursing home are **assessed** on an ongoing basis;
- (c) the plan of care is revised as necessary **when the resident's requirements change**;
- (d) an **opportunity to participate fully** in the development and revision of the resident's plan of care is provided to,
  - (i) the resident
  - (ii) if the resident is mentally incapable, his or her **substitute decision maker**

#### Findings:

1. The substitute decision maker (SDM) had suggested collecting a specimen to check for infection because the resident was more confused. The record also shows that the resident was symptomatic. The SDM also requested that a doctor see the resident. According to the progress notes, neither occurred until after the resident had fallen on more than one occasion. The resident was diagnosed in hospital with an infection. The SDM was not given the opportunity to participate fully in the plan of care.
2. The health record indicates that resident was restless, wandering, confused and complaining of abdominal discomfort and experiencing urinary incontinence. There was no further assessment by nursing staff in relation to the reported symptoms.

Inspector ID#: 146

Signature of Licensee of Designated Representative  
Signature du Titulaire du représentant désigné

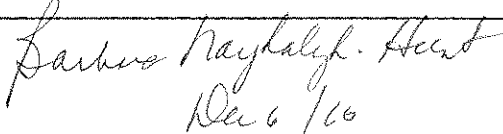
Signature of Health System Accountability and Performance Division  
representative/Signature du (de la) représentant(e) de la Division de la  
responsabilisation et de la performance du système de santé.

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Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

 Dec 6 / 16		
<b>Title:</b>	<b>Date:</b>	<b>Date of Report (if different from date(s) of inspection).</b>