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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2015	2015_265526_0015	H-002460-15, AND H-002915-15	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

Long-Term Care Home/Foyer de soins de longue durée

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

THERESA MCMILLAN (526)

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): August 5 and 6, 2015.

The following complaints were inspected: H-002460-15 and H-002915-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Nursing, Medical Director/Physician, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and family members.

During the course of the inspection, the inspector reviewed resident health records and observed resident care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 ensure that the resident, the SDM, if any, or the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A) Resident #200 was admitted to the home in 2014. Review of their health record and interviews with registered and non registered staff indicated that the resident had exhibited physical aggression toward themselves, staff and co-residents since admission. Review of progress notes indicated that resident #200 exhibited physical aggression over a three month time period in 2015.

On a specified day in 2015, the resident was assessed by a physician and a new medication was prescribed. According to progress notes, resident #200 continued to exhibit physical aggression on several occasions during the next 10 days, and was observed being physically aggressive toward resident #201 who became injured and required treatment. The day following this incident, the primary physician changed resident #200's medications and a new medication was prescribed and administered.

Progress notes and interviews with registered staff revealed that the resident was unable to consent or make decisions about their own care; their substitute decision maker (SDM) was informed the day following the change in medications and expressed concerns about the changes made. Following continued aggressive behaviour over four days since the medication changes, the primary physician increased the medication

dosage.

During interview the SDM stated that they had not been made aware of the resident being prescribed the new medication until 20 days later. In addition, progress notes, staff interviews and interview with resident #200’s SDM indicated the SDM did not want resident #200 to receive the medication prescribed by the primary physician, had not provided consent and had informed staff of this at a minimum five times. Progress notes and entries in the “Doctor’s Book” revealed that the SDM alerted staff to the changes in the resident's behaviour since medication changes had been initiated.

During an interdisciplinary team meeting, it was determined that the resident should continue to receive the medication. The primary care physician reported to the LTC Inspector of being aware of the SDM's concerns and did not change the medication as they weren't sure if it was necessary. They stated that they assessed the resident seven days after the medication had been increased, and met with SDM; the medication was discontinued at that time. Progress notes indicated that the resident's lethargy continued. Two days after the medication was discontinued, the resident was found drooling and unresponsive and was sent to hospital.

The Director of Care (DOC) and the physician confirmed that the SDM was not provided the opportunity to participate in the decision to administer the new medications to resident #200 over a specified period in 2015.

B) Registered staff confirmed during interview that resident #202 was not able to consent or participate in decisions about their care. Review of resident #202's health record indicated that they had been ordered changes to three different medications on specified days in 2015.

The "POA [power of attorney] Notified" boxes on the Physician's Order Sheet for each medication change had not been signed to indicate the POA/SDM had been notified of the change. Review of the health record revealed that no note was found to indicate that the resident's SDM had consented to the medication changes; the RPN confirmed this during interview. According to the Medication Administration Record (MAR), the medication changes were implemented as ordered and without participation or consent from the resident's POA/SDM. The RPN could not confirm that resident #202's SDM had been given the opportunity to participate fully in the development and implementation of the resident's plan of care.

C) Registered staff confirmed during interview that resident #203 was not able to consent or participate in decisions about their care. Review of resident #203's health record indicated that they had been ordered three medication changes on a specified day in 2015.

The "POA Notified" boxes on the Physician's Order Sheet for each medication change had not been signed to indicate the POA/SDM had been notified. During interview, an RPN confirmed that no note was found in the progress notes to indicate that the resident's POA/SDM had consented to the medication changes. According to the MAR, the medication changes were implemented as ordered and without consent or the involvement of the resident's POA/SDM.

The RPN could not confirm that resident #203's SDM had been given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of resident #200’s health records indicated that they wandered, were resistant to care, were not easily redirected and had exhibited physical aggression 11 times over a two month time period in 2015.

The resident was then assessed by a geriatrician and a new medication was prescribed. According to progress notes, the resident continued to exhibit physical aggression on at least five occasions over the 10 day period that followed. One of these incidents involved the injury of resident #201 for which they required treatment. The day after this incident, a new medication was prescribed by the resident's primary care physician, and increased the dose three days later.

Interviews with staff and the DOC indicated that staff normally assessed the effect of medications on residents and documented their observations using the resident’s progress notes, entries into the “Doctor’s Book” and Direct Observation (DOS) charting as needed. Review of progress notes indicated that, the resident began exhibiting deterioration in at least four areas of activities of daily living within one week of the medication change.

Interview with registered staff and review of the "Doctors Book" indicated that staff documented the resident's SDM's complaints about the medication and about the resident's behaviour and care need changes.

Registered staff could not confirm that the physician was contacted directly to inform them of the resident's deterioration as noted in progress notes and the "Doctor's Book". The physician confirmed that they knew about the SDM's concerns, attempted to contact them, was not aware of the extent of the resident's change in condition and had not assessed the resident to determine this.

An interdisciplinary team convened and determined that the resident should continue to be administered the medication. One week after the medication was increased, the physician met with the SDM, assessed the resident, and the new medication was discontinued. Progress notes indicated that the resident's deterioration in health continued; they were found drooling and unresponsive and were sent to hospital.

The DOC, physician and registered staff confirmed that resident #200 had not been reassessed when their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 17th day of September, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2015_265526_0015
Log No. / Registre no:	H-002460-15, AND H-002915-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 21, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall do the following:

A) Provide the opportunity for all residents or substitute decision makers (SDMs) as appropriate, to give consent or participate fully in the development and implementation of the resident's plan of care specifically regarding medication changes.

B) Inform all residents or SDM's as appropriate of the consequences of giving or refusing consent for the change in medication.

C) Document if and when residents or their SDM's as appropriate, participated in the development and implementation of the plan of care, provided consent and that they were informed of the consequences of giving or refusing consent for the medication change.

D) Educate direct care staff on the home's policy and/or expectations regarding giving residents or their substitute decision makers the opportunity to participate fully in the development and implementation of the resident's plan of care.

Grounds / Motifs :

1. This non compliance has been issued as a VPC on April 12, 2013; and as a VPC on December 8, 2011.

2. The licensee failed to ensure that the resident, the SDM, if any, or the designate of the resident/SDM were provided the opportunity to participate fully

in the development and implementation of the plan of care.

A) Resident #200 was admitted to the home in 2014. Review of their health record and interviews with registered and non registered staff indicated that the resident had exhibited physical aggression toward themselves, staff and co-residents since admission. Review of progress notes indicated that resident #200 exhibited physical aggression over a three month time period in 2015.

On a specified day in 2015, the resident was assessed by a physician and a new medication was prescribed. According to progress notes, resident #200 continued to exhibit physical aggression on several occasions during the next 10 days, and was observed being physically aggressive toward resident #201 who became injured and required treatment. The day following this incident, the primary physician changed resident #200's medications and a new medication was prescribed and administered.

Progress notes and interviews with registered staff revealed that the resident was unable to consent or make decisions about their own care; their substitute decision maker (SDM) was informed the day following the change in medications and expressed concerns about the changes made. Following continued aggressive behaviour over four days since the medication changes, the primary physician increased the medication dosage.

During interview the SDM stated that they had not been made aware of the resident being prescribed the new medication until 20 days later. In addition, progress notes, staff interviews and interview with resident #200's SDM indicated the SDM did not want resident #200 to receive the medication prescribed by the primary physician, had not provided consent and had informed staff of this at a minimum five times. Progress notes and entries in the "Doctor's Book" revealed that the SDM alerted staff to the changes in the resident's behaviour since medication changes had been initiated.

During an interdisciplinary team meeting, it was determined that the resident should continue to receive the medication. The primary care physician reported to the LTC Inspector of being aware of the SDM's concerns and did not change the medication as they weren't sure if it was necessary. They stated that they assessed the resident seven days after the medication had been increased, and met with SDM; the medication was discontinued at that time. Progress notes indicated that the resident's lethargy continued. Two days after the medication

was discontinued, the resident was found drooling and unresponsive and was sent to hospital.

The Director of Care (DOC) and the physician confirmed that the SDM was not provided the opportunity to participate in the decision to administer the new medications to resident #200 over a specified period in 2015.

B) Registered staff confirmed during interview that resident #202 was not able to consent or participate in decisions about their care. Review of resident #202's health record indicated that they had been ordered changes to three different medications on specified days in 2015.

The "POA [power of attorney] Notified" boxes on the Physician's Order Sheet for each medication change had not been signed to indicate the POA/SDM had been notified of the change. Review of the health record revealed that no note was found to indicate that the resident's SDM had consented to the medication changes; the RPN confirmed this during interview. According to the Medication Administration Record (MAR), the medication changes were implemented as ordered and without participation or consent from the resident's POA/SDM. The RPN could not confirm that resident #202's SDM had been given the opportunity to participate fully in the development and implementation of the resident's plan of care.

C) Registered staff confirmed during interview that resident #203 was not able to consent or participate in decisions about their care. Review of resident #203's health record indicated that they had been ordered three medication changes on a specified day in 2015.

The "POA Notified" boxes on the Physician's Order Sheet for each medication change had not been signed to indicate the POA/SDM had been notified. During interview, an RPN confirmed that no note was found in the progress notes to indicate that the resident's POA/SDM had consented to the medication changes. According to the MAR, the medication changes were implemented as ordered and without consent or the involvement of the resident's POA/SDM.

The RPN could not confirm that resident #203's SDM had been given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall do the following:

A) Develop formal strategies that direct staff in the standardized assessment of residents who have undergone changes to their medications, particularly psychotropic medication.

B) Develop formal strategies for documenting assessments of residents who have undergone changes to their medications.

C) Develop formal strategies for the immediate notification of the interdisciplinary team that a resident has had a change in their condition related to medication changes.

D) Train staff in these formalized strategies regarding the assessment, documentation and notification of the interdisciplinary team when residents have had changes in their condition related to changes in medications.

E) Conduct quarterly and annual evaluations of medication administration as it relates to psychotropic drug use and its effects on residents.

Grounds / Motifs :

1. This non compliance was previously issued as a VPC and CO on June 16,

2014; as a VPC and CO on June 10, 2013; as a VPC on January 24, 2013; and as a CO on March 9, 2012.

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Review of resident #200's health records indicated that they wandered, were resistant to care, were not easily redirected and had exhibited physical aggression 11 times over a two month time period in 2015.

The resident was then assessed by a geriatrician and a new medication was prescribed. According to progress notes, the resident continued to exhibit physical aggression on at least five occasions over the 10 day period that followed. One of these incidents involved the injury of resident #201 for which they required treatment. The day after this incident, a new medication was prescribed by the resident's primary care physician, and increased the dose three days later.

Interviews with staff and the DOC indicated that staff normally assessed the effect of medications on residents and documented their observations using the resident's progress notes, entries into the "Doctor's Book" and Direct Observation (DOS) charting as needed. Review of progress notes indicated that, the resident began exhibiting deterioration in at least four areas of activities of daily living within one week of the medication change.

Interview with registered staff and review of the "Doctors Book" indicated that staff documented the resident's SDM's complaints about the medication and about the resident's behaviour and care need changes.

Registered staff could not confirm that the physician was contacted directly to inform them of the resident's deterioration as noted in progress notes and the "Doctor's Book". The physician confirmed that they knew about the SDM's concerns, attempted to contact them, was not aware of the extent of the resident's change in condition and had not assessed the resident to determine this.

An interdisciplinary team convened and determined that the resident should

continue to be administered the medication. One week after the medication was increased, the physician met with the SDM, assessed the resident, and the new medication was discontinued. Progress notes indicated that the resident's deterioration in health continued; they were found drooling and unresponsive and were sent to hospital.

The DOC, physician and registered staff confirmed that resident #200 had not been reassessed when their care needs changed. [s. 6. (10) (b)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

Service Area Office /
Bureau régional de services : Hamilton Service Area Office