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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 22, 2016	2016_553536_0019	031493-16, 031659-16	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

CATHIE ROBITAILLE (536)

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): November 14 and 15, 2016.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Staff, Resident Care Co-Ordinator, and the Assistant Director of Care (ADOC).

During the course of the inspection, the inspector observed the provision of care and services, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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. (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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each in the assessment of the resident so that their assessments are integrated, consistent with and complimented each other.

On an identified date, resident #001 was sent to the hospital. The following day, the resident returned to the home with a prescription from the hospital physician. Staff #108 called the resident's physician and obtained an order for only two of the three recommended treatment orders. Staff #108 confirmed that the order for the identified treatment was not obtained and resident #001 did not receive this ordered treatment. [s. 6. (4) (a)]

2. The licensee failed to ensure that resident #001 was being reassessed and the plan of care was revised when care set out in the plan had not been effective, and different approaches were considered in the revision of the plan of care.

A) A review of resident #001's clinical record identified, that between their admission date and November 2016 the resident had an identified number falls. All of these falls occurred in the resident's room. Identified interventions were noted in the resident's plan of care. Staff #107 identified, resident #001 had a high low bed; however, it was not utilized due to residents attempts to self-transfer. Staff #100 when interviewed was asked if there were any other fall prevention measures that could be utilized in regards to preventing falls. Staff #100 provided Inspector with a list of other fall prevention measures that had not yet been implemented for resident #001.

B) A review of resident #001's clinical record also identified, that a toileting schedule had been created with the resident and family due to issues with toileting and incontinence. During interview with the family, it was identified that resident #001 was attempting to self-toilet on their own, was having falls and could no longer follow the toileting schedule. During interviews with Personal Support Workers (PSWs), staff #101, #102 and #103 they all stated that resident was not on a toileting schedule and would be toileted when they were agreeable to assistance or care. Despite the care plan not being effective it was not updated. [s. 6. (11) (b)]

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 and ensuring that staff and others collaborate in the assessment of the resident #001and plan of care revised because care set out in the plan has not been effective, and different approaches considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 ensure that resident #001 who was demonstrating responsive behaviours had actions taken to respond to the needs of the resident including assessment, reassessments and interventions, and that the resident's responses to interventions were documented.

A review of resident #001's clinical record for a specified date was completed. It identified that the resident had a specified number of documented incidents where the resident refused care, medications or going to dining room for meals. A review of the nursing flow sheets also noted, that due to resident #001's resistance to care, the resident had missed a specified number of baths in an identified number of weeks. A review of resident #001's care plan identified that no changes had been made since the multidisciplinary care conference addressing the resident's resistance to care eight months earlier. On a specified date, the resident's family called the home with a complaint. It was not until that complaint that the home made a referral for resident #001, to the specialized resource of the Behavioural Support Ontario (BSO) team, to review and assess the resident's ongoing resistance to care. During interview with staff #100 and staff #107 they both confirmed, that the staff working with resident #001 had normalized the resident's ongoing refusal of care. [s. 53. (4) (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 and ensuring that residents demonstrating responsive behaviours have actions taken to respond to the needs of the resident including assessment, reassessment and interventions, and that the resident's response to interventions are documented, to be implemented voluntarily.

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Issued on this 22nd day of November, 2016

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

Original report signed by the inspector.