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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_546585_0015	003711-17	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

LEAH CURLE (585)

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 8, 9, 10, 11, 14, 15, 16, 17, 18, 2017.

This inspection was conducted concurrent to Resident Quality Inspection (RQI) #2017_542511_0011.

During the course of the inspection, the inspector(s) spoke with family, personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), an Assistant Director of Nursing (ADOC), the Executive Director of Nursing (DOC) and the Registered Dietitan (RD).

During the course of the inspection, the inspector(s) toured the home, conducted observations of resident rooms, reviewed clinical records, polices and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation

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. (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 :

The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident’s care needs changed.

Resident #202’s written plan of care, updated October 2016, identified an intervention that outlined how staff were to provide treatment related to specified condition, to assess the effectiveness of the treatment and consult with the physician to make adjustments as needed.

On identified dates in November 2016, the resident experienced five falls. Review of documentation in their clinical record from November 2016 revealed over a span of six days, the resident expressed symptoms associated with the specified condition as a result of their recent falls.

On an identified date in November 2016, after the resident experienced multiple falls, the resident’s Substitute Decision Maker (SDM) requested interventions regarding the specified condition be modified. On the same day, staff documented a voicemail was left for the physician.

The next day, an assessment was completed and identified the resident was demonstrating symptoms related to the specified condition. Staff documented that no changes were made to the plan of care and the assessment did not identify whether any treatment or interventions were provided following the assessment.

On the day of the fifth fall, staff documented that the resident’s SDM reported to staff that the resident continued to demonstrate symptoms related to the specified condition.

The next day, staff documented that the resident continued to demonstrate symptoms and the physician was notified. Later that day, the physician ordered a new intervention to treat the resident's symptoms. The next day, the new intervention was implemented and staff documented the intervention was effective in treating the symptoms.

Interview with Registered Practical Nurse (RPN) #160 confirmed the resident experienced a change in condition and new interventions were not implemented to treat the specified condition until an identified date in November 2016; which was multiple days after the resident and SDM first vocalized they were experiencing symptoms related to the specified condition and after the resident experienced five falls.

Additional non-compliance related to s. 6. (10)(b) was identified in Resident Quality Inspection report #2017_542511_0011 (log #013990-17) conducted concurrent to this complaint inspection. [s. 6. (10) (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 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 the resident’s care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires, any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation 79/10, s. 48. (1) requires every licensee of a long-term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's falls policy, "Falls Prevention and Management, Policy Number POL/3", last revised October 27, 2015, identified that when a fall occurs, Head Injury Routine (Nursing Standard – Head Injury Routine {H.I.R.}), will be followed for an un-witnessed fall where the resident is unable to accurately report if they hit their head.

On a specified date in October 2016 and two specified dates in November 2016, resident #202 experienced unwitnessed falls. Review of the clinical record revealed that HIR was not completed as per the required schedule post-fall following the resident's falls, which was confirmed by RPN #180.

Interview with the DOC who confirmed HIR was to be completed when a resident experienced an unwitnessed fall or hit their head.

Additional non-compliance related to r. 8. (1)(b) was identified in Resident Quality Inspection report #2017_542511_0011 (log #013990-17) conducted concurrent to this complaint inspection. [s. 8. (1) (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 ensure that the home's falls prevention and management program to reduce the incidence of falls and the risk of injury is complied with, to be implemented voluntarily.

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.