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 prévue le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2018;	2018_689586_0014 (A1)	008298-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

Ontario

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Removal of potential PHI from public report.

Issued on this 10 day of August 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by JESSICA PALADINO (586) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 2, 3, 4, 8, 9, 10, 11, 14, 15, 16, 17, 18, 22, 23, 24 and 25, 2018.

The following Complaint inspections were conducted during this RQI inspection:

Log #019080-17 related to alleged abuse;

Log #028479-17 related to falls, responsive behaviours, and alleged neglect;

Log #003614-18 related to alleged resident to resident abuse;

Log #004894-18 related to responsive behaviours and therapy services; and

Log #005503-18 related to staffing.

The following Critical Incident System (CIS) inspections were conducted during this RQI inspection:

Log #022118-17 related to alleged resident to resident abuse;

Log #022805-17 related to alleged resident to resident abuse;

Log # 024826-17 related to falls prevention;

Log #000448-18, CIS #2975-000001-18 related to alleged resident to resident abuse;

Log #002682-18, CIS #2975-000012-18 related to alleged resident to resident abuse;

Log #003308-18, CIS #2975-000016-18 related to alleged resident to resident abuse;

Log #003545-18, CIS #2975-000017-18 related to alleged resident to resident abuse;

Log #003917-18, CIS #2975-000020-18 related to fall with injury;

Log #005155-18, CIS #2975-000023-18 related to alleged resident to resident abuse;

Log #005961-18, CIS #2975-000015-18 related to infection control;

Log #006255-18, CIS #2975-000018-18 related to infection control;

Log #006310-18, CIS #2975-000019-18 related to infection control;

Log #007515-18, CIS #2975-000026-18 related to infection control;

Log #007664-18, CIS #2975-000027-18 related to infection control;

Log #009095-18, CIS #2975-000029-18 related to infection control; and

Log #009184-18, CIS #2975-000031-18 related to infection control.

The following Follow Up inspections were completed during this RQI inspection:

Log #023798-17 related to O. Reg. 79/10, s. 8. (1) b;

Log #026103-17 related to LTCHA, 2007, s. 20 and s. 19(1);

Log #026389-17 related to O. Reg. 79/10, s. 53. (4);

Log #026395-17 related to LTCHA, 2007, s. 6 (7);

Log #026398-17 related to LTCHA, 2007, s. 6 (11);

Log #026399-17 related to O. Reg. 79/10, s. 50 (2);

Log #026401-17 related to O. Reg. 79/10, s. 8. (1) b; and

Log #026403-17 related to LTCHA, 2007, s. 20.

The following intakes were completed in this RQI Inspection:

Log #020444-17, CIS #2975-000024-17; Log #027027-17, CIS #2975-000040-17; Log #027517-17, CIS #2975-000041-17; and Log #002593-18, CIS #2975-000011-18 related to a fall with injury for which the resident was taken to hospital and that resulted in a significant change in condition.

Inspector #674 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim President, the Administrator, Director of Quality, Performance Systems and Food Services, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Coordinators (RCC), Resident Assessment Inventory (RAI) Coordinators, the Medical Director, the Infection Control staff person, the A/R Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance staff, residents, and families.

During the course of this inspection, inspector(s) toured the home, observed dining service, observed resident-staff interactions and care, reviewed health records, policies and procedures, training records, manufacturers' instructions, audits, infection control documents, complaints logs, staff files, and resident

and family council meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

- **16 WN(s)**
- **11 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 20. (1)	CO #001	2017_690130_0001	123
LTCHA, 2007 s. 20. (1)	CO #006	2017_542511_0011	123
O.Reg 79/10 s. 53. (4)	CO #001	2017_542511_0011	682
LTCHA, 2007 s. 6. (11)	CO #003	2017_542511_0011	506
LTCHA, 2007 s. 6. (7)	CO #002	2017_542511_0011	506
O.Reg 79/10 s. 8. (1)	CO #001	2017_690130_0002	611
O.Reg 79/10 s. 8. (1)	CO #005	2017_542511_0011	611

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone. O.Reg. 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A. The home submitted a CIS report that documented an incident of inappropriate sexual touching by resident #047 to resident #048. Resident #047 had a history of verbal responsive behaviours according to clinical health records. It was also identified that there was a history of incidents between the two residents.

In an interview with staff #141 they indicated that resident #047 has a history of responsive behaviours which had escalated in the week prior to the reported incident, and that resident #048 triggered behaviours in resident #047.

During an interview RCC #112 stated that resident #048 was cognitively impaired and did not consent to resident #047's physical contact. The home failed to ensure that resident #048 was protected from abuse by anyone (682).

B. The home submitted a CIS report that documented an incident of inappropriate sexual behaviour from resident #044 to resident #045. Resident #044 had a history of sexually inappropriate behaviour according to the CIS report and the resident's health record.

There was a previous incident of a similar nature documented in the resident progress notes. Staff #010 confirmed resident #044 had a history of sexually inappropriate behaviour and confirmed that resident #044 sexually abused resident #045. Resident #045 was not protected from sexual abuse by resident #044 [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In May 2018, RCC #110 verified the expectation of the licensee was that all areas of skin integrity would be assessed weekly and recorded separately for each area of altered skin integrity in the resident's clinical record in Point Click Care (PCC), assessment tab, under the 'SJV Skin and Wound Assessment'.

A. Resident #098 was identified with an area of altered skin integrity. Review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. In May 2018, RCC #114 confirmed that the weekly

skin assessments had not been completed for resident #098.

B. Resident #095 was admitted to the home with multiple areas of altered skin integrity. Review of the clinical record confirmed that weekly wound assessments had not been completed. In May 2018, RCC #114 confirmed that the weekly skin assessments had not been completed.

C. Resident #092 was identified with several areas of altered skin integrity. A review of the clinical record did not include a reassessment of all areas of altered skin integrity on a weekly basis. RCC #110 confirmed that the weekly skin assessments had not been completed. Interview with the Administrator confirmed that the home had been completing routine audits for the completion of weekly wound assessments and identified that there had been improvements in the weekly skin and wound assessments, but that this was still not being completing consistently. (506).

D. Resident #037 was identified with an area of altered skin integrity. Review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. It was identified that a skin and wound assessment was completed. In May 2018, RCC #112 confirmed that the weekly skin assessments had not been completed.

E. A compliance due date of December 29, 2017, for CO #004 from inspection 2017_542511_0011 that required weekly reassessments of residents' altered skin integrity. Review of resident #037's clinical record indicated that they continued to exhibit altered skin integrity; however, during resident #037's clinical record review weekly reassessments of the area of altered skin integrity could not be located. In May 2018, RCC #112 confirmed that the weekly skin assessments had not been completed. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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).

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 there was a written plan of care for each resident that set out, (a) the planned care for the resident.

A. CIS report #2975-000023-18 was reviewed and it was noted that resident #051 had interventions in place to prevent interactions with resident #044.

PSW #128 confirmed the above strategies were implemented for resident #051. Inspector and PSW #128 observed the intervention in place; however, the plan of care including resolved items was reviewed and it did not contain any information related to the above interventions. This was verified by registered staff #111 who immediately entered the information into the plan of care. The written plan of care for resident #051 did not contain the planned care for the resident related to safety.

This area of non-compliance was identified during a CIS inspection, log #005155-18 conducted concurrently during this RQI.

B. Registered staff #110 reported that resident #045 had interventions in place to prevent contact with resident #044. Inspector and registered staff #111 observed the intervention in place.

The plan of care for resident #045 including resolved items was reviewed and it did not contain any information related to the resident's use of the intervention. This was confirmed by registered staff #111 who immediately entered the information into the plan of care. The written plan of care for resident #045 did not contain the planned care for the resident in relation to safety.

This area of non-compliance was identified during a CIS inspection, log #000448-18 conducted concurrently during this RQI. (123).

C. Review of resident #037's written plan of care indicated that the resident demonstrated responsive behaviours and included that they had frequent falls. Progress notes identified that the resident fell while they were sitting alone in their room.

During interview in May 2018, resident #037's substitute decision maker (SDM) reported to LTC Inspector #526 that they had found the resident without a specific intervention in place that had been discussed with the home. A progress note indicated that the SDM specifically requested this intervention. In an interview during the RQI, PSW #128 stated that the intervention should have been n place; however, it was not, as noted on multiple occasions by the LTC Inspector throughout the inspection.

The written plan of care did not include the specific intervention. During interview on May 22, 2018, ADOC #107 stated that the written plan of care did not set out the planned care in relation to resident #037.

D. According to the Resident Assessment Inventory Minimum Data Set (RAI MDS), resident #037 was incontinent and included their level of assistance required for toileting. During interviews PSWs #100 and #138 reported that resident #037 would exhibit a specific behaviour if they had to use the toilet so staff would toilet them at specific times of the day with effect. Review of the document the home

referred to as resident #037's documented care plan indicated that the resident was not toileted and continence was managed through checking continence products and containment. During interview in May 2018, ADOC #107 stated that the written plan of care did not set out resident #037's planned care in relation to toileting. [s. 6. (1) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised 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.

On an identified date in 2017, the home submitted a CIS report #2975-000033-17, which indicated that resident #047 exhibited responsive behaviours with staff. Resident #047 was witnessed to have inappropriately touched resident #048 without consent.

A clinical record review indicated that resident #047 had a known history of responsive behaviours. Progress notes reviewed indicated there had been multiple recorded occasions where the resident demonstrated responsive behaviours which posed a risk to themselves or co-residents.

A review of the written plan of care stated that interventions had been implemented to manage responsive behaviours. RCC #141 stated in an interview that resident #047 did not have a specific intervention in place when the reported incident occurred as the intervention was not implemented. Resident's #047 plan of care was not updated when the interventions in place were not effective in preventing the responsive behaviours.

This area of non-compliance was identified during a CIS inspection, log #022805-17 conducted concurrently during this RQI. [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 to ensure that there is a written plan of care for each resident that set out the planned care for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A. The record of resident #045 was reviewed including documentation in the progress notes and it was noted that on an identified date in 2017, the resident activated the call bell and reported to the staff that resident #044 was displaying

sexually inappropriate behaviour toward them. Resident #045 got scared and pushed the call bell for help right away.

CIS report #2975-000001-18 was reviewed and it indicated that the alleged sexual abuse incident occurred and the information was reported to the Director.

The Administrator confirmed that the incident occurred on an identified date in 2017 and the after-hours pager was reported to the Director four days later. They also reported that the staff that was present did not provide all the relevant information at the time. When they arrived in the home and followed-up they realized that it should have been reported to the Director immediately so they completed and submitted the CIS report. The Administrator confirmed that the registered staff were to have immediately reported the incident to the Director. The registered staff were educated about the need to immediately report and the information was posted at all nursing stations.

The home did not ensure that a person who had reasonable grounds to suspect that the abuse of resident #045 by anyone had occurred of may occur, immediately reported the suspicion and the information upon which it was based to the Director.

This area of non-compliance was identified during a CIS inspection, log #000448-18 conducted concurrently during this RQI.

B. CIS report #2975-000023-18 was reviewed and identified that on an identified date in 2018, resident #051's spouse reported to the staff that the resident wanted to move due to inappropriate sexual behaviour by resident #044. This was confirmed through review of resident #051's health record, including progress notes. It was noted that the incident was reported to the home on an identified date in 2018 and the report was submitted to the Director the following day. The Administrator confirmed the information in the CIS report and progress notes as above and confirmed that the staff did not immediately report the incident of alleged sexual abuse to the Director as per the licensee's policy and procedure.

This area of non-compliance was identified during a CIS inspection, log #005155-18 conducted concurrently during this RQI. This was also issued in relation to follow-ups #026103-17 and #026403-17. [s. 24. (1)]

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 that the person who has reasonable grounds to suspect that any of the following has occurred or may have occurred, immediately reports the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health

conditions, including allergies, pain, risk of falls and other special needs.

According to a Critical Incident report #2975-000034-17 that was submitted to the Director on an identified date in 2017, resident #056 sustained a fall.

i. The fall resulted in transfer to the hospital with a diagnosis of a significant injury. Review of the post-fall assessment identified the resident as being high risk for falls. Review of the resident's clinical record indicated when the resident returned from the hospital, fall interventions were put in place. The written plan of care for resident #056 did not include a falls focus or any interventions to mitigate the risk for falls. Interview with RCC #109 and RCC #110 confirmed the plan of care did not include care needs based on the assessments of the resident.

ii. Resident #056 returned from hospital with the order to provide palliative care. Review of the resident's clinical record confirmed that they returned from hospital with the order for palliative care measures; however, the written plan of care for resident #056 did not include palliative care focus or any interventions to support end-of-life care. Interview with RCC #109 and RCC #110 confirmed the written plan of care did not include the resident care needs, based on the assessments.

This area of non-compliance was identified during a CIS inspection, log #024826-17 conducted concurrently during this RQI. [s. 26. (3) 10.]

2. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 14. Hydration status and any risks relating to hydration.

The licencee's policy, "Nutrition & Hydration Management" (policy number FOO-POL/06, last revised August 2016), directed staff to complete the Food & Fluid Intake Form for each resident following meal service and nourishment pass. The forms included the following statement, "If < 6 glasses (1200 ml) of fluids are consumed each day for 3 consecutive days refer to RN or RPN". The policy also indicated that if a resident consumed less than six glasses or 1,200 millilitres (ml) for three consecutive days, the PSW, RN or RPN were to refer the resident to the RD.

Resident #062's plan of care indicated that they were at a risk of dehydration. The most recent MDS Assessment included a fluid goal and coded that they were dehydrated.

The resident was under surveillance for a respiratory infection on two occasions in 2018. In an interview with PSW #103, they indicated that the resident's intake had decreased since they had been ill.

A review of the resident's Food & Fluid Intake Form identified that the resident had consumed less than six fluid servings on 5 consecutive days. In an interview with RD #108, they indicated that they had not received a referral for the resident's poor fluid intake, and acknowledged that they should have received one; therefore, they did not assess the resident for their poor fluid intake.

Resident #062's plan of care was not based on their hydration status and risks related to hydration. [s. 26. (3) 14.]

3. The licensee failed to ensure that each care plan was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions.

Resident #042's health record indicated that they had developed an area of altered skin integrity. RPN #122 completed a skin assessment and sent a referral for a specific intervention. A review of the resident's documented plan of care, which front line staff use to direct care, did not include a skin and wound focus or information regarding the new area of altered skin integrity. Interview with DOC #107 confirmed that resident #042's care plan did not include the area of altered skin integrity. [s. 26. (3) 15.]

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 that a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs; 14. Hydration status and any risks relating to hydration; and, 15. Skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

According to a CIS report # 2975-000034-17 and review of the resident #056's progress notes, on an identified date in 2017, resident #056 experienced an unwitnessed fall.

Review of the resident's clinical record identified that a post-fall assessment was not completed after the fall. Interview with Administrator confirmed that when the resident fell from their bed, a post-fall assessment was not completed.

This area of non-compliance was identified during a CIS inspection, log #024826-17 conducted concurrently during this RQI. [s. 49. (2)]

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 that when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A. The licensee's policy titled, "Identification of Potential Risk and Management of a Resident with Responsive Behaviours" (last reviewed November 2017), stated resident's with responsive behaviours were to wear a specific risk identifier. This was used to inform staff and others in identifying and minimizing the risk of altercations and potentially harmful interactions and signaled additional care needs and preventative measures for safety.

According to CIS report #2975-000012-18 and review of the resident's health record, the plan of care for resident #054 directed staff to ensure the resident was wearing a specific identifier. Resident #054's Violence Assessment Tool (VAT) indicated that the resident was a risk for violence. Interview with RCC confirmed that the resident was not wearing the specific identifier that was used to alert staff and others of the potential for aggressive behaviours. Observation of resident #054 on two occasions during the RQI revealed that the resident was not wearing the specific identifier t to identify their violence risk.

The RCC confirmed in May 2018, that the intervention was not implemented at the time of this inspection and it was to be used to inform staff and others in identifying and minimizing the risk of altercations and potentially harmful interactions. (506).

B. Resident #049 was identified as a high risk for violence towards co-residents and staff. Resident #049 shared a room with resident #043.

A review of CIS report #2975-000016-18 indicated that on an identified date in 2018, PSW staff responded to yelling coming from the resident's room. The staff observed an incident of aggression between resident #049 and #043.

The residents were separated by staff and assessed for injuries. Resident #043sustained injuries. Resident #049 had no injuries; however, was transferred to hospital for further assessment of responsive behaviours.
Resident #049 remained in hospital for several days and returned to the home on an identified date in 2018. The resident's plan of care was updated upon re-admission and interventions were initiated.

A review of resident #049's clinical record indicated that on an identified date, one of the interventions was not in place. During interview with DOC #106 they indicated that the intervention was not in place.

It was confirmed through documentation and during interview with DOC #106 that the licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents when the specified intervention was not implemented.

This area of non-compliance was identified during a CIS inspection, log #003308-18 conducted concurrently during this RQI. [s. 55. (a)]

2. The licensee failed to ensure that all direct care staff were advised at the beginning of every shift of each resident whose behaviours including responsive behaviours, require heightened monitoring because those behaviour's pose a potential risk to the resident or others.

A clinical record review indicated that resident #069 had a history of responsive

behaviour which included a potential for violent behaviours.

A review of the written plan of care stated that interventions had been implemented to manage responsive behaviours.

During an interview in May 2018, RCC #110 indicated that the PSW flow sheet binder included the safety plan and scripted responses for resident #069 and that staff were expected to review the binder. RCC #110 also stated that resident #069 refused a specified intervention. During an interview in May 2018, PSW #128 confirmed they were providing care to resident #069 for an entire shift and stated that they were not aware of resident's #069 responsive behaviour management plan or the safety plan. The home failed to ensure all direct care staff were advised at the beginning of every shift of resident's #069 behaviours that pose a potential risk to resident or others. [s. 55. (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 to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and to ensure that all direct care staff are advised at the beginning of every shift of each resident whose behaviours including responsive behaviours, require heightened monitoring because those behaviour's pose a potential risk to the resident or others, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who received training under subsection 76. (2) of the LTCHA, 2007, received retraining in the areas mentioned in that subsection and that it be annually in accordance with O. Reg. 79/10 section 219. (1).

According to Critical Incident Submissions between a four month period in 2018, the home declared five Acute Respiratory Illness (ARI) and two Enteric Illness infectious disease outbreaks.

Review of staff training records provided to Long Term Care Inspector #526 indicated that 80% of all staff in the home had received annual retraining in 2017 for the home's infection prevent and control (IPAC) program that included hand hygiene, 83% had received retraining for donning and doffing personal protective equipment (PPE), and 81% of direct care staff had received IPAC General Cleaning retraining. During interview, the Director of Quality, Performance Systems

and Food Services confirmed that not all staff in the home had received annual retraining for the home's infection prevention program in 2017. (526). [s. 76. (4)]

2. A. The licensee failed to ensure that direct care staff were provided with training on the prevention of abuse and neglect in accordance with O. Reg. 79/10 section 221. (2) 1 that this training be conducted annually.

The St Joseph's Villa Education Completion Summary Report for the period: January 1- December 31, 2017 SURGE e-learning and Supplemental Education with Nurse Educator was reviewed. It indicated that 80 percent (%) of all staff completed the education module 'Prevention of Abuse/Neglect'. Inspector #526 confirmed the accuracy of this information with staff member #111.

The home did not ensure that all staff received retraining annually related to prevention of abuse, neglect and retaliation.

This area of non-compliance was identified related to the follow-up #026103-17 as the education required in the order was not 100 per cent completed, as well as a result of CIS inspections #005155-18 and #000448-18. (123).

B. The licensee failed to ensure that direct care staff were provided with training on how to minimize the restraining of residents and how to restrain residents in accordance with O. Reg. 79/10 section 221. (2) 1 that this training be conducted annually.

Two identified residents (#037 and #035) were observed with specific restraints that were not applied according to manufacturers' instructions on multiple occasions during the inspection. During interviews with PSWs #138, #144 and #145, they stated that they thought that the loose restraints were applied appropriately, stated not remembering when they had received their training, and PSW #144 and RPN #101 could not locate the instructions on safe application of the specified restraints.

The Administrator provided records for the home's "Restraints and Personal Assistance Service Devices (PASDs)" training that identified that 298/341 (87.4%) of direct care staff received the annual retraining in 2017. The Administrator confirmed that not all direct care staff had received annual retraining in 2017 on restraining residents or on the manufacturer's instructions on safe application of the specified restraints. (526). [s. 76. (7) 4.]

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 that the persons who received training under subsection 76. (2) of the LTCHA, 2007, received retraining in the areas mentioned in that subsection and that it be annually in accordance with O. Reg. 79/10 section 219. (1), to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that home's infection prevention and control program included measures to prevent the transmission of infections.

The home's Infection Control "Management of Respiratory Symptoms/Outbreaks" policy (number POL/17, last revised May 2018), directed staff that if a resident presented with respiratory infection symptoms, "a droplet-contact precautions sign will be posted on the entrance to the room in a basic accommodation by the registered staff or PSW". The home's Infection Control "Routine Practices" policy (number POL/1 last reviewed May 2018), directed staff that protective attire/equipment that were to be available to staff

were gowns, aprons, goggles, masks, face shields, PPE holders, gloves and disposal systems for syringes/sharps.

A. CIS report #2975-000029-18 was submitted to the Director to report ARI involving eight residents on an identified home area. The line list with residents affected by the illness was provided to LTC Inspector #526 by RPN #115 and identified that three residents' symptoms had resolved with nine residents (#077, #078, #079, #080, #084, #085, #086, #087, #088) who continued to have symptoms that required droplet
precautions to be used by LTCH staff.

During tour of the home area it was noted that residents' #078, #079 and #080 rooms were not identified by droplet precautions signage or had PPE supplies readily available to staff. Review of residents' #078, #079 and #080 health records indicated that they continued to exhibit respiratory illness symptoms. During interview, RPN #115 and RCC #110 confirmed that these residents should have had droplet precaution signage and PPE available to LTCH staff and visitors to prevent the transmission of infection on the home area.

B. CIS report #2975-000031-18 was submitted to the Director to report ARI involving four residents on an identified home area. The line list with residents affected by the illness was provided to LTC inspector #526 by RPN #118 and identified that seven residents' symptoms had resolved with four residents (#081, #082, #083, and #030) who continued to demonstrate symptoms that required droplet precautions to be used by staff. During tour of the home area it was noted that resident #083's room was not identified by droplet
precautions signage or had PPE supplies readily available to staff even though the resident was identified on the line list. Review of residents #083's health records indicated that they continued to exhibit respiratory illness symptoms on that date.

PSW #119 was observed providing snack nourishment to resident #083 but without PPE in place; the resident was observed to have a productive cough while sitting in their bed. During interview, PSW #119 stated they were asked to provide nutrition to resident #083 and that they did not know if the resident was on the ARI line list, but if they were, there would be a droplet precaution sign and PPE posted outside of their door. The PSW stated that providing care for resident #083 without wearing PPE could result in the spread of infection. During interview, RCC #114 confirmed that resident #083 should have had droplet precaution signage and PPE available to LTCH staff and visitors to prevent the transmission of infection on the home area

and proceeded to put these infection control measures in place. [s. 86. (2) (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 to ensure that home's infection prevention and control program includes measures to prevent the transmission of infections, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On September 25, 2017, the following compliance order (CO #001) from inspection #2017_690130_0002 was made under O. Reg. 79/10, s. 8 (1):

1. The licensee shall ensure that staff at the home comply with the home's policies and procedures related to medication administration.
2. The licensee shall ensure that training is provided to all appropriate staff to ensure their understanding and responsibilities related to these policies.
3. The licensee shall ensure that audits are completed related to compliance with these policies and the results of those audits are acted upon if required.

The compliance date was January 19, 2018.

The licensee completed steps 1 and 3 in CO #001.

The licensee failed to complete step 2 in CO #001.

During the inspection, the home's policy titled, "Nursing Standard-Medication Administration" (revision date November 2017) was reviewed.

The home's Education Completion Summary Report was reviewed. This report included SURGE e-learning education, as well as what the home refers to as supplemental education that was provided on the same topic. Based on the information provided, 40% of appropriate registered staff did not complete the training on the above noted policy.

In May 2018, the Administrator and the Director of Quality, Performance Systems and Food Services confirmed that all appropriate registered staff did not receive the required training on the home's policy titled,"Nursing Standard-Medication Administration", as specified in step 2 of CO #001. [s. 101. (3)]

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 that the licensee complies with every order made or agreement entered into under this Act and those Acts, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions (if any).

The manufacturer's instructions titled, "Pelvic Support Belt, Installation and User's Instructions" for the application of lap belts was provided by the Administrator to LTCH Inspector #526 which stated the following: "the pelvic support belt must be worn tightly fitted across the lower pelvis or thighs at all times. A loose belt can allow the user to slip down and create a risk of strangulation." and "Adjustment: when properly adjusted and the belt tightened, it should fit snug so that the user's pelvis is secure."

A. According to the written plan of care and interviews with PSW's #100 and #138, resident #037 had a lap belt that was applied as a restraint. During resident observations on three occasions during the inspection, the lap belt was noted to be loosely applied to approximately four inches from the resident's pelvis. RPN #101,

PSW #139 and RPN #129 confirmed that the lap belt was too loose, not applied according to manufacturer's instructions and they tightened it so that it was snug against the resident's pelvis. PSW #138 stated that they thought that the loose lap belt was applied correctly. During interview, PSWs #138 and #139 stated that they could not remember the last time they were trained about the application of lap belts.

B. According to the written plan of care, resident #035 had a lap belt that was applied as a restraint. PSW #144 confirmed its use. Resident #035 was observed sitting in their wheelchair and the lap belt was applied but at least four inches from their pelvis.

During interviews with PSWs #144 and #145 while observing the resident, they both stated that the lap belt was applied correctly. RPN #143 reported that the lap belt was loose and tightened it.

When asked where PSWs would find the instructions for the application of the lap belt according to manufacturer's instructions they said it should be in the nurse's station. PSW #145 and RPN #101 conducted a search of the nursing station and were unable to locate a copy of the manufacturer's instructions on how to apply resident #035's lap belt.

During interview, the Administrator stated that staff did not have ready access to manufacturer's instructions on how to safely apply lap belts. They also stated that it was the home's expectation that lap belts be applied snugly against a resident's pelvis and if it was applied loosely, it was not applied according to manufacturer's instructions. [s. 110. (1) 1.]

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 that the physical device applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use by the prescriber.

A. A review of the medication incidences was conducted for a three month period in 2018. This review identified that on an identified date in 2018, resident #096 had an order on their clinical health record from the physician to receive a specific dosage of a medication, except for three days per week where they would receive a lower dose. This order was not immediately processed and resident #096 received one of the higher dosages of the medication, which should have been discontinued, and the newly prescribed dose should have been administered.

During an interview conducted with registered staff #147 it was confirmed that the orders for resident #096 were not processed and this resident did not receive the medication as prescribed by the prescriber. It was also confirmed by the ADOC that this resident did not receive their medication as specified by the prescriber.

B. A medication incident final report was completed for resident #003 for a medication incident that occurred on an identified date in 2018 This resident had a physician's order to reduce a medication dosage. This order was immediately processed. The pharmacy sent both doses of this medication on the same medication card, and each dose in the card was the original higher dosage. For a three month period, resident #003 was administered the incorrect dosage at one of their administration times.

In an interview conducted with the ADOC it was confirmed that this resident did not receive the medication as specified by the prescriber. [s. 131. (2)]

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 that drugs are administered to residents in accordance with the directions for use by the prescriber, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

Observation on two occasions during the inspection confirmed resident #070's personal care items such as their toothbrush and hairbrush were not labelled in a shared washroom. Interview with PSW #121 and RN #125 confirmed that all oral care items were to be labelled. [s. 229. (4)]

2. The licensee failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

The home's Administrator reported to LTC Inspector #526 that the home had declared an outbreak for ARI on an identified home area. The line list with residents affected by the illness was provided to LTC Inspector #526 by RPN #115 who confirmed that the list included resident #078. Review of resident #078's Infection Assessment indicated that they had been having respiratory symptoms for a few days prior; however, review of progress notes and the assessment tab of the electronic documentation system failed to identify a record of the resident's symptoms or if immediate action had been taken. The resident's room did not have a droplet precaution sign or PPE available to staff during observation throughout the inspection. During interview, the home's Infection Control staff #120 stated that resident #078's respiratory symptoms should have been recorded and immediate actions taken to address resident #078's respiratory symptoms. [s. 229. (5) (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 to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Resident #020 was admitted to the home in 2012. The written plan of care at the time of the admission indicated that this resident required bed rails. A review of the clinical health records for resident #020 took place during this inspection. When the bed rails were initiated for this resident, a bed rail assessment was not completed.

An interview was conducted with DOC #107 and it was acknowledged that an assessment of resident #020's bed system was not completed when the bed rails were implemented. [s. 15. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A. Resident #059's documented plan of care included the use of a specific PASD and directed staff to document the resident's use of this every hour in the PASD Flowsheet Record along with ensuring that the resident was repositioned at least every two hours.

The resident was observed during the inspection with the PASD in place. In an interview with PSW #100 and RPN #101, both indicated that they were to fill out PASD/Restraint Flowsheets for residents who required the use of a PASD. Upon review of the flowsheet binder, no PASD/Restraint Flowsheet could be located for resident #059. A review of their hard copy chart included flowsheets for six months prior; however, no records for May 2018, could be found. PSW #100 and RPN #101 indicated that the resident was repositioned every two hours; however, confirmed that this was not documented.

B. Resident #042's SDM voiced concern to the LTCH Inspector that prior to the resident's discharge from the home, an oral hygiene issue was identified, as confirmed through progress note documentation and interview with RCC #109, causing the SDM to question if regular oral care was being completed at that time. A review of the resident's nursing flow sheets over a three month period identified 23 blank entries under 'mouth care'. In an interview with the ADOC #107, they acknowledged that documentation should have been completed. [s. 30. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Review of progress notes indicated that on an identified date in 2017, resident #037 sustained a fall that resulted in a transfer to hospital and significant injury. They returned to the home the following day and physiotherapy became involved to manage the resident's range of motion.

A search of CIS reports submitted by the home failed to identify a report made to the Director by the home in relation to resident #037's fall that resulted in injury and a transfer to hospital. During interview, ADOC #107 reported that resident #037 had a significant change in condition after their fall and went to hospital and that a report had not been submitted to the Director. [s. 107. (3) 4.]

Issued on this 10 day of August 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JESSICA PALADINO (586) - (A1)

Inspection No. / No de l'inspection : 2018_689586_0014 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 008298-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 10, 2018;(A1)

Licensee / Titulaire de permis :
St. Joseph's Health System
50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6

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 : Mieke Ewen

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_690130_0001, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

The licensee shall prepare and implement a plan to ensure that all residents, including resident #045, are protected from sexual abuse by resident #044 and to ensure that all residents, including resident #048, are protected from sexual abuse by resident #047.

The plan must include a documented interdisciplinary review of residents' #044 and #047 plans of care to evaluate the effectiveness of interventions in place to manage sexual responsive behaviors.

A written record of the plan is to be kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone. O.Reg. 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A. The home submitted a CIS report that documented an incident of inappropriate sexual touching bu resident #047 to resident #048. Resident #047 had a history of verbal responsive behaviours according to clinical health records. It was also identified that there was a history of incidents between the two residents .

In an interview with staff #141 they indicated that resident #047 has a history of responsive behaviours which had escalated in the week prior to the reported incident, and that resident #048 triggered behaviours in resident #047.

During an interview RCC #112 thry stated that resident #048 was cognitively impaired and did not consent to resident #047's physical contact. The home failed to ensure that resident #048 was protected from abuse by anyone (682).

B. The home submitted a CIS report that documented an incident of inappropriate sexual behaviour from resident #044 to resident #045. Resident #044 had a history of sexually inappropriate behaviour according to the CIS report and the resident's health record.

There was a previous incident of a similar nature documented in the resident progress notes. Staff #010 confirmed resident #044 had a history of sexually inappropriate behaviour and confirmed that resident #044 sexually abused resident #045. Resident #045 was not protected from sexual abuse by resident #044. (123).

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to two out of six residents reviewed. The home had a level 4 compliance history as they had non-compliance with this section of the LTCHA that included:
• written notification (WN) issued October 26, 2017 (2017_542511_0011); and,
• compliance order (CO) #002 issued October 11, 2017 with a compliance due date of January 11, 2018 (2017_690130_0001). (123)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Aug 07, 2018

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2017_542511_0011, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 50 (2).

The licensee shall ensure that residents #037, #098, #092 and #095, and any other resident with altered skin integrity, have weekly skin assessments completed.

Specifically, the licensee must:
1. Audit the clinical record of all remaining residents in the home who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, ensuring that residents with altered skin integrity are assessed at least weekly by a member of the registered nursing staff.

2. Continue to conduct audits to ensure ongoing compliance with weekly skin assessments. The audits are to be documented and kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

In May 2018, RCC #110 verified the expectation of the licensee was that all areas of skin integrity would be assessed weekly and recorded separately for each area of altered skin integrity in the resident's clinical record in Point Click Care (PCC), assessment tab, under the 'SJV Skin and Wound Assessment'.

A. Resident #098 was identified with an area of altered skin integrity. Review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. In May 2018, RCC #114 confirmed that the weekly skin assessments had not been completed for resident #098.

B. Resident #095 was admitted to the home with multiple areas of altered skin integrity. Review of the clinical record confirmed that weekly wound assessments had not been completed. In May 2018, RCC #114 confirmed that the weekly skin assessments had not been completed.

C. Resident #092 was identified with areas of altered skin integrity. A review of the clinical record did not include a reassessment of all areas of altered skin integrity on

a weekly basis. RCC #110 confirmed that the weekly skin assessments had not been completed. Interview with the Administrator confirmed that the home had been completing routine audits for the completion of weekly wound assessments and identified that there had been improvements in the weekly skin and wound assessments, but that this was still not being completing consistently. (506).

D. Resident #037 was identified with an area of altered skin integrity. Review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. It was identified that a skin and wound assessment was completed. In May 2018, RCC #112 confirmed that the weekly skin assessments had not been completed.

E. A compliance due date of December 29, 2017, for CO #004 from inspection 2017_542511_0011 that required weekly reassessments of residents' altered skin integrity. Review of resident #037's clinical record indicated that they continued to exhibit altered skin integrity; however, during resident #037's clinical record review weekly reassessments of the area of altered skin integrity could not be located. In May 2018, RCC #112 confirmed that the weekly skin assessments had not been completed. (526).

The severity of this issue was determined to be a level 3 as there was actual harm to resident #092. The scope of the issue was a level 3 as it related to four out of four residents reviewed. The home had a level 5 compliance history as they had multiple non-compliance with at least one related compliance order with this section of the LTCH Regulations that included:
• voluntary plan of correction (VPC) issued March 8, 2016 (2016_188168_0001);
• VPC issued October 17, 2016 (2016_275536_0016); and,
• compliance order (CO) #004 issued October 26, 2017 with a compliance due date of December 29, 2017 (2017_542511_0011). (526)

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

Sep 05, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

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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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PALADINO - (A1)

Ontario

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Service Area Office / Bureau régional de services : Hamilton