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 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

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

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 03, 2019	2019_549107_0007 (A1)	010342-18, 011131-18, 015104-18, 016239-18, 025406-18, 026684-18, 027200-18, 032692-18, 002568-19	Critical Incident System

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

Amended by MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Edits to public report

Issued on this 3 rd day of July, 2019 (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

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by MICHELLE WARRENER (107) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 22, 25, 27, 28, 29, April 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 2019.

This Critical Incident Inspection was completed concurrently with Follow Up Inspection 2019_541169_0012, Complaint Inspection 2019_570528_0012, and Complaint Inspection 2019_541169_0011.

Findings of non-compliance identified during this Critical Incident Inspection related to O.Reg. 79/10, s.8(1)(b) can be found on Complaint Inspection report 2019_570528_0012.

Findings of non-compliance identified through Complaint Inspection report 2019_570528_0012 related to LTCHA, 2007, S.O. 2007, Chapter 8, s.6(7) and O.Reg. 79/10, s.30(2) can be found on this Critical Incident report.

The following intakes were completed in this Critical Incident System Inspection:

Log #016239-18, CIS#2975-000048-18 was related to falls

Log #002568-19, CIS#2975-000061-18 was related to falls

Log #025406-18, CIS#2975-000060-18 was related to falls

Log #026684-18, CIS#2975-000063-18 was related to falls

Log #032692-18, CIS#2975-000071-18 was related to injury of unknown origin

Log #011131-18, CIS#2975-000039-18 was related to resident to resident altercation with injury

Log #010342-18, CIS#2975-000038-18 was related to resident to resident altercation with injury

Log #015104-18, CIS#2975-000046-18 was related to resident to resident altercation with injury

Log #027200-18, CIS#IL-60775-AH/2975-000065-18 was related to resident to resident altercation with injury.

During the course of the inspection, the inspector(s) spoke with residents, families, the Administrator, Directors of Care (DOC), Director of Quality, Performance Systems & Food Services, Resident Care Managers (RCM), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Medical Director, Infection Control, Registered Nursing staff and Health Care Aides (HCA), Physiotherapist, Occupational Therapist, Physiotherapy Assistant, Agency staff, Executive Secretary, Registered Dietitians (RD), Food Services Manager (FSM), Food Services Supervisors (FSS), Housekeeping/Laundry Manager, and Behaviour Support Ontario (BSO).

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to residents #023 and #034 as specified in the plan related to falls prevention.

A. Review of Log #002568-19 and Critical Incident System #2975-000061-18, identified an incident of fall with injury for resident #023.

On a specified date, a Fall Risk Assessment Tool for resident #023 identified that the resident had a risk for falls. The plan of care directed staff to provide specific fall prevention strategies. Several days later, resident #023 had a fall resulting in injury to the resident. Interview with Resident Care Manager (RCM) #153 identified that PSW staff had not followed the fall prevention strategies identified in the resident's plan of care. Interview with RN #109 also confirmed that the fall prevention strategies were not implemented as required in their plan of care. (528)

B. The plan of care for resident #034 identified that the resident was at risk for falls and was required to have fall prevention strategies in place. On a specified date, the provision of care and services were observed on a specific home area

over a 2.25 hour period. Personal Support Worker (PSW) #176 was observed providing care to resident #034. When the PSW left the room the resident was observed without their fall prevention strategies in place. The PSW returned after providing care to co-residents, approximately seven minutes later, and implemented the fall prevention strategies. Interview with PSW #176 and RPN #119 confirmed that the resident was at risk for falls and required the fall prevention strategies to be in place. (528) [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in their plan related to supervision while eating.

Resident #008's care plan, the document staff referred to for providing care to the resident, identified the resident had nutritional risks and required supervision while they were eating.

On a specified date, Inspector #107 observed the resident eating without supervision. Inspector #107 notified HCA #129 who then provided supervision of the resident. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to residents #041, #054, and #025 as specified in their plan related to responsive behaviours.

A. The licensee failed to ensure that the care set out in the plan of care was provided to resident #041 as specified in their plan related to responsive behaviours.

This non-compliance was issued due to critical incident #2975-000039-18, involving an altercation between two residents that resulted in injury.

Resident #041 had a plan of care that identified the resident had responsive behaviours and identified the triggers for the responsive behaviours.

Resident #041 was assessed and a plan of care developed where resident #041 was to receive a specific behavioural strategy, due to the responsive behaviours. The plan of care for resident #041 directed staff to provide the responsive behaviour strategy on all three shifts.

For the time period reviewed by Inspector #169, the responsive behaviour strategy was required on 15 days (at three shifts per day) for a total of 45 shifts, however, the behavioural strategy was only provided for 40 shifts. There were five shifts where resident #041 did not receive care according to the plan of care.

Interview with DOC #188 confirmed the plan of care specified for resident #041 related to responsive behaviours was not provided. (169)

B. The licensee failed to ensure that the care set out in the plan of care was provided to resident #054 as specified in their plan related to responsive behaviours.

This non-compliance was issued due to critical incident #2975-000038-18, involving an altercation between two residents that resulted in injury.

The plan of care for resident #054 directed staff to provide a specific behavioural strategy on all three shifts. For the time period reviewed by Inspector #169, the behavioural strategy was required on 53 days (at three shifts per day) for a total of 159 shifts, however, the strategy was only provided on 57 shifts.

Interview with DOC #188 confirmed the plan of care specified for resident #054 related to responsive behaviours was not provided. (169)

C. The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 as specified in their plan related to responsive behaviours.

Resident #025's care plan, the document that provided direction to staff providing care, directed staff to provide a specific behavioural strategy on two out of three shifts. RPN #184 stated that when the strategy was not in place, resident #025 exhibited responsive behaviours.

Progress notes in the resident's clinical health record reflected that the behavioural strategy was not in place on a specified date when it was required, and the resident exhibited responsive behaviours. The strategy was also not provided on another specified date, and the resident exhibited responsive behaviours most of the shift. RPN #184 also confirmed that on an additional date

the behavioural strategy was not provided as specified in resident #025's care plan.

During interview with Health Care Aide (HCA) #149 they stated that the behavioural strategy for resident #025 was not consistently provided according to the resident's plan of care.

During interview, RPN #184 confirmed that resident #025 did not consistently receive the behavioural strategy on the required shifts. (107) [s. 6. (7)]

4. The licensee failed to ensure that the following was documented for resident #055: the provision of specific responsive behaviour strategies, the outcome of the care set out in the plan of care, and the effectiveness of the plan of care in relation to responsive behavioural strategies.

Critical Incident #2975-000046-18 occurred involving an altercation between two residents that resulted in injury. The plan of care for resident #055 identified specific triggers for the responsive behaviours and resident #055 had a history of responsive behaviours. Documentation on a Behavioural Support Ontario (BSO) note identified specific triggers for the resident's responsive behaviours.

After the above noted Critical Incident, a behavioural strategy was initiated, however, it was unclear from the documentation if the strategy was consistently provided, and the duration that the strategy was required or in place.

The resident's care plan (the document that provided direction to staff providing care) identified the behavioural strategy was required for a specific shift. The strategy was initiated after the critical incident and was not discontinued on the care plan until the resident was discharged.

Documentation in a Behavioural Supports Ontario record identified that the behavioural strategy was required until a certain date; however, "Risk Rounds" documentation in the resident's progress notes on the same date, still identified the strategy and did not indicate that the strategy was discontinued. In the "Risk Rounds" progress note days later, the strategy was not identified, however, documentation reflected that the resident's Substitute Decision Maker (SDM) was updated on the previous date, with the risk rounds information and current interventions in place. Further "Risk Rounds" documentation was not included in the resident's record until over one month later, after several responsive

behaviours occurred. A documented evaluation of the outcome of the behavioural strategy or the effectiveness of the strategy was not included in the resident's record when it was discontinued.

Registered Practical Nurse #196, who routinely worked with the resident, was also unable to identify when the strategy was discontinued. The RPN stated that they felt that the strategy was effective for the resident when it was in place.

During interview with Inspector #107, DOC #186 could not confirm if the required strategy was provided on required shifts or after the date the BSO document indicated the strategy would be discontinued. Review of documentation over a two month period identified inconsistencies related to the specific behavioural strategy. Director of Care #186 confirmed during interview with Inspector #107 that it was unclear from the records when the behavioural strategy had been provided or was discontinued. [s. 6. (9)]

5. The licensee failed to ensure that resident #022 was reassessed and their plan of care related to falls was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Critical Incident System (CIS) #2975-000060-18, log #025406-18, was submitted to the MOHLTC for an incident that caused an injury to a resident and resulted in a significant change in the resident's health status.

On a specified date, resident #022 was assessed by the Physiotherapist (PT) #180, and they identified the resident's risk for falls had increased. Over a six month period, resident #022 fell on five occasions. As a result of the fifth fall, the resident sustained significant injuries. The plan of care did not include a revision of falls risk or falls interventions.

Interview with PT #180 confirmed they documented their assessment electronically but did not verbally communicate the change in fall risk to nursing staff. Interview with Resident Care Manager (RCM) #156, confirmed that the written plan of care was not reviewed and revised when the resident's falls risk changed and they could not demonstrate any revisions related to fall prevention interventions at that time.

The home failed to ensure that resident #022 was reassessed and the plan of care reviewed and revised, when the resident's risk level increased. [s. 6. (10) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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 with s. 6(10)(b) 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,
(b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 resident #022, under the Fall Prevention and Management program, including assessments, reassessments, interventions, and the resident's responses to interventions, were documented.

Critical Incident System (CIS) #2975-000060-18, log #025406-18, was submitted to the Ministry of Health and Long Term Care for an incident that caused an injury to a resident and resulted in a significant change in the resident's health status.

The Home's Policy titled, "Falls Prevention Management", stated "using the shift report/transfer of accountability, the fall needs to be monitored and communicated for the next 72 hours so that follow up interventions can be monitored and carried out as necessary".

During a review of resident #022's falls history and their progress notes, it was identified that the resident did not consistently have documentation of their falls follow-up assessment for 72 hours, as per the requirement in the home's policy, for six identified falls.

During an interview with DOC #186, it was identified that it was an expectation of the home for registered staff to document their follow up assessment of resident #022's falls in their progress notes. It was also identified that the follow up assessments should have included the resident's injury, pain, or skin issues as a result of the fall. An interview with DOC #186 further identified that the 72 hours post-fall assessment documentation should have been completed by registered staff for each shift, for 72 hours after the fall incidents.

The DOC verified, upon review of resident #022's progress notes, that the six fall incidents on the specified dates were missing a complete 72 hour post-fall follow up documentation.

The licensee failed to ensure that any action taken with respect to resident #022's post-fall assessments were documented. [s. 30. (2)]

2. The licensee failed to ensure that actions taken with respect to residents #017 and #014, under the Dietary Services and Hydration program, including assessments and reassessments, interventions, and the resident's responses to interventions, were documented.

On a specified day, resident #017 was provided with an assistive device during an observed meal service. The Registered Dietitan revised the resident's plan of care to include the assistive device the same day. Documentation in the resident's progress notes did not reflect an assessment in relation to the need for

the assistive device.

On a specified day, resident #014 received an assistive device at an observed meal service. The Registered Dietitian revised the resident's plan of care to include the assistive device the same day, however, documentation did not include an assessment of the resident in relation to the need for the assistive device.

During interview with Registered Dietitian #139 they confirmed that they had not documented an assessment of the residents in relation to the assistive devices and had just updated the residents' plans of care to include the devices. [s. 30. (2)]

3. The licensee failed to ensure that actions taken with respect to resident #044, under the nursing and personal support services program, including assessments and reassessments, interventions and the resident's responses to interventions were documented.

On an identified day, resident #044 had a fall. Review of the progress notes included a description of the incident, however, did not include the assessment of the resident.

During interview with Inspector #107, RPN #182 and RPN #116, who were involved in the fall, confirmed that a post fall assessment was completed immediately post fall, however, the assessment was not documented in the resident's record.

The home's policy, "Falls Prevention and Management POL/3", directed the RN/RPN to perform a head to toe assessment of every resident after they had fallen before moving the resident and to document all findings in the Point Click Care (PCC) Fall Incident Assessment.

During interview with Inspector #107, RPN #182 stated that all documentation related to the fall would be in the PCC progress notes and was not recorded in other locations within the resident's record. The RPN reviewed the progress notes with Inspector #107 and confirmed that the documentation did not include the assessment of the resident that was completed right after the fall. The staff could not remember why the assessment was not documented in the resident's progress notes, as required in the home's policy. [s. 30. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure no person mentioned in subsection (1) performed their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities.

This non-compliance was identified in relation to critical incident #2975-000039-18 that involved an altercation between two residents and resulted in harm to a

resident. A staff member was to provide behavioural strategies for resident #041 and was not trained on the policy POL/10, named, "Identification of Potential risk and management of a resident with responsive behaviours".

The policy POL/10, named, "Identification of Potential risk and management of a resident with responsive behaviours", provided direction to staff about care strategies designed to reduce and to mitigate the impact of responsive behaviours on the quality of life of the affected resident and those living and working in their shared environment including staff and visitors. The policy directed staff on how to manage responsive behaviour incidents.

On a specified date, a staff person was to provide behavioural strategies for resident #041. A responsive behaviour incident occurred involving resident #041 and another resident. The staff member #192 was not trained in the policy and did not implement care strategies.

The plan of care for resident #041 identified the resident had responsive behaviours. If a responsive behaviour were to occur, the plan of care directed staff to implement specific strategies. The staff member was not aware of the plan of care, nor were they provided training about the specific care needs for the resident.

Inspector #169 interviewed staff member #192. Staff member #192 was able to recall the responsive behaviour incident and stated they were assigned to resident #041. During the interaction, staff member #192 did not follow the strategies identified in the home's policy. The staff member confirmed they had not completed the personal support worker program and were still in training. The staff member confirmed they had never received any training from the licensee about specific approaches to care. The staff member also confirmed they were not aware of the resident's individual plan of care.

The DOC confirmed the staff member did not receive the appropriate training.

The licensee did not ensure that agency staff member #192 was provided training relating to behaviour management and specifically the plan of care related to resident #041. [s. 76. (2) 10.]

Issued on this 3 rd day of July, 2019 (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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by MICHELLE WARRENER (107) - (A1)
Inspection No. / No de l’inspection :	2019_549107_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	010342-18, 011131-18, 015104-18, 016239-18, 025406-18, 026684-18, 027200-18, 032692-18, 002568-19 (A1)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 03, 2019(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:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

(A1)
The licensee must be compliant with s. 6(7) of the LTCHA.

Specifically the licensee must:
a) Ensure residents #023 and #034, and any other residents, are provided with falls prevention interventions required as per the plan of care.
b) Ensure that resident #025, and any other residents, are provided with responsive behaviour interventions required as per the plan of care.
c) Conduct an audit, at a schedule of the homes choosing, to ensure that the falls prevention and responsive behaviour interventions are provided to residents as specified in their plan of care.
c) Keep a documented record of the audit.

Grounds / Motifs :

(A1)
1. The licensee failed to ensure that the care set out in the plan of care was provided to residents #023 and #034 as specified in the plan related to falls prevention.

A. Review of Log #002568-19 and Critical Incident System #2975-000061-18, identified an incident of fall with injury for resident #023.

On a specified date, a Fall Risk Assessment Tool for resident #023 identified that the resident had a risk for falls. The plan of care directed staff to provide specific fall prevention strategies. Several days later, resident #023 had a fall resulting in injury to the resident. Interview with Resident Care Manager (RCM) #153 identified that PSW staff had not followed the fall prevention strategies identified in the resident's plan of care. Interview with RN #109 also confirmed that the fall prevention strategies were not implemented as required in their plan of care. (528)

B. The plan of care for resident #034 identified that the resident was at risk for falls and was required to have fall prevention strategies in place. On a specified date, the provision of care and services were observed on a specific home area over a 2.25 hour period. Personal Support Worker (PSW) #176 was observed providing care to resident #034. When the PSW left the room the resident was observed without their fall prevention strategies in place. The PSW returned after providing care to co-residents, approximately seven minutes later, and implemented the fall prevention strategies. Interview with PSW #176 and RPN #119 confirmed that the resident was at risk for falls and required the fall prevention strategies to be in place. (528) [s. 6. (7)] (528)

2. The licensee failed to ensure that the care set out in the plan of care was provided to residents #041, #054, and #025 as specified in their plan related to responsive behaviours.

A. The licensee failed to ensure that the care set out in the plan of care was provided to resident #041 as specified in their plan related to responsive behaviours.

This non-compliance was issued due to critical incident #2975-000039-18, involving an altercation between two residents that resulted in injury.

Resident #041 had a plan of care that identified the resident had responsive behaviours and identified the triggers for the responsive behaviours.

Resident #041 was assessed and a plan of care developed where resident #041 was to receive a specific behavioural strategy, due to the responsive behaviours. The plan of care for resident #041 directed staff to provide the responsive behaviour strategy on all three shifts.

For the time period reviewed by Inspector #169, the responsive behaviour strategy was required on 15 days (at three shifts per day) for a total of 45 shifts, however, the behavioural strategy was only provided for 40 shifts. There were five shifts where resident #041 did not receive care according to the plan of care.

Interview with DOC #188 confirmed the plan of care specified for resident #041 related to responsive behaviours was not provided. (169)

B. The licensee failed to ensure that the care set out in the plan of care was provided to resident #054 as specified in their plan related to responsive behaviours.

This non-compliance was issued due to critical incident #2975-000038-18, involving an altercation between two residents that resulted in injury.

The plan of care for resident #054 directed staff to provide a specific behavioural strategy on all three shifts. For the time period reviewed by Inspector #169, the behavioural strategy was required on 53 days (at three shifts per day) for a total of 159 shifts, however, the strategy was only provided on 57 shifts.

Interview with DOC #188 confirmed the plan of care specified for resident #054 related to responsive behaviours was not provided. (169)

C. The licensee failed to ensure that the care set out in the plan of care was provided to resident #025 as specified in their plan related to responsive behaviours.

Resident #025's care plan, the document that provided direction to staff providing care, directed staff to provide a specific behavioural strategy on two out of three shifts. RPN #184 stated that when the strategy was not in place, resident #025

exhibited responsive behaviours.

Progress notes in the resident's clinical health record reflected that the behavioural strategy was not in place on a specified date when it was required, and the resident exhibited responsive behaviours. The strategy was also not provided on another specified date, and the resident exhibited responsive behaviours most of the shift. RPN #184 also confirmed that on an additional date the behavioural strategy was not provided as specified in resident #025's care plan.

During interview with Health Care Aide (HCA) #149 they stated that the behavioural strategy for resident #025 was not consistently provided according to the resident's plan of care.

During interview, RPN #184 confirmed that resident #025 did not consistently receive the behavioural strategy on the required shifts. (107) [s. 6. (7)]

The severity of this issue was a level two. The scope was level two as 2/4 residents reviewed related to falls management and 3/4 residents reviewed related to responsive behaviours (62.5%) were non-compliant with s. 6(7). Compliance history was a level three as there were previous non-compliances, WN, VPC, or complied CO, one of which is the same subsection being cited:
Voluntary Plan of Correction (VPC) issued October 5, 2016, (2016_449619_0025),
VPC issued April 4, 2017, (2017_57610a_0005),
Compliance Order #002 issued October 26, 2017, due date of December 8, 2017, and complied June 14, 2018 (2017_542511_0011).
(107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

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:

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 3 rd day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MICHELLE WARRENER (107) - (A1)

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

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