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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 20, 2019	2019_555506_0005	012940-19	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

LESLEY EDWARDS (506)

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): July 16, 18, 19, 22, 23, 24, 25, 26, August 7, 8, 9, 12 and 13, 2019.

Critical Incident System (CIS) Log #012940-19- related to abuse and neglect, transferring and positioning, medication administration, nutrition and hydration, responsive behaviours and personal support services.

This inspection was completed concurrently with Complaint Inspection #2019_555506_0006.

Non compliance related to Ontario Regulation 79/10 s. 6 (7) identified during inspection of log #014636-19 is included in this inspection report and issued as a written notification.

Non compliance related to Ontario Regulation 79/10 s. 53 identified during inspection of log #014636-19 is included in this inspection report and issued as a voluntary plan of correction.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Cares (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), Resident Care Co-ordinator, Manager of Environmental Services, Convalescent Care Lead, personal support workers (PSW), housekeeping staff, Admission Co-ordinator, residents and families.

During the course of the inspection, the inspector observed the provision of care and services, medication administration, nourishment pass, reviewed videos, clinical records, policies and procedures and investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The home submitted a CIS report on an identified date in 2019, identifying that the resident had been positioned flat in bed while being offered fluids and food. The licensee's policy " Safe Feeding Techniques While Feeding in Bed" confirmed that the resident should be sitting upright and centred in the bed as close to 90 degrees as possible and head should be upright. If the resident starts coughing, staff will encourage the resident to cough and avoid using fluids to "wash the food down". The staff providing assistance to residents to eat must sit at eye level while feeding and after eating the resident should remain in an upright position for at least 30 to 60 minutes.

A. On an identified date in 2019, PSW #106 was observed giving resident #001 a drink while the resident was lying flat, on their side and the PSW was standing over the resident. The Administrator confirmed that PSW #106 did not use safe feeding and positioning techniques when assisting resident #001.
B. On an identified date in 2019, RPN #114 was observed giving resident #001 a drink while the resident was lying flat and on their side. The RPN was standing over the resident and giving the resident a drink. The Administrator confirmed that PSW #106 did not use safe feeding and positioning techniques when assisting resident #001.
C. On an identified date in 2019, RPN #105 was observed giving resident #001 their meal while standing. The resident was noted to be positioned at approximately 60 degrees however; the resident's body or head was not in the centre of the bed and the head was noted to be tilted to one side and not upright or centred. The resident was heard coughing frequently throughout their meal while being given food and fluids. RPN #105 was also observed giving the resident a drink while coughing. At no time during the meal service when the resident was noted to be coughing did the RPN reposition the resident. Once the meal was completed RPN #105 was observed putting the resident back down flat immediately after the meal. The Administrator confirmed on an identified date in July 2019, that RPN #105 did not use safe feeding and positioning techniques when assisting resident #001.
An interview with Registered Dietitian #114 also confirmed that the above feeding techniques were not considered safe for resident #001.
[s. 73. (1) 10.]

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 home has proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CIS report identifying inappropriate transferring of resident #001. Resident #001's plan of care identified that resident #001 was to be transferred a specific way. The licensee's policy "Resident Handling: Lift, Transfers and Repositioning" confirmed that mechanical lifting equipment are to be operated with two staff present at all times.

A. On an identified date in 2019, PSW #103 was seen transferring resident #001 by themselves. The Administrator confirmed that PSW #103 did not use safe transferring and positioning techniques when assisting resident #001.
B. On an identified date in 2019, PSW #103 was observed transferring resident #001 by themselves using a device. The Administrator confirmed that PSW #103 did not use safe transferring and positioning techniques when assisting resident #001
C. On an identified date in 2019, PSW #103 was observed transferring resident #001 by themselves with a device. The Administrator confirmed that PSW #103 did not use safe transferring and positioning techniques when assisting resident #001.
D. On an identified date in 2019, PSW #109 and #107 were observed completing transfer with resident #001 and did not use the appropriate device. The Administrator confirmed on an identified date in 2019, that PSW #109 and #107 did not use safe transferring and positioning techniques when assisting resident #001.
E. On an identified date in 2019, PSW #109 was observed putting resident #001 back to bed transferring the resident by themselves. The Administrator confirmed on an identified date in 2019, that PSW #109 did not use safe transferring and positioning techniques when assisting resident #001.
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 all staff use safe transferring and positioning devices when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between meal beverage in the morning.

On an identified date in 2019, an observation was completed by the LTC homes inspector on the unit from 0940 until 1230 hours. During this time a between meal beverage was not provided to the residents on this unit. Interview with PSW #118, #119 and #120 at 1205 hours, confirmed that they had not offered the residents a between meal beverage at this time and PSW #118 confirmed that they just lost track of time. The LTC homes inspector informed the RCC and the Administrator that this was not completed and confirmed that it is the expectation that this is done between 1000 and 1030 daily. [s. 71. (3) (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 each resident is offered a minimum of a between meal beverage in the morning, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, behavioural triggers were identified, strategies were developed, implemented and actions were taken to respond to the needs of the resident, including assessments and reassessments.

Resident #006 was admitted to the home and a review of the clinical record confirmed that resident #006 was displaying responsive behaviours. It was documented that these responsive behaviours occurred 17 times over a three month period in 2019. The resident's Admission Minimum Data Set Assessment confirmed that the resident was displaying responsive behaviours on a daily basis and was not easily altered. The written plan of care for resident #006 did not include a responsive behaviour focus with any identified triggers or include any strategies or any interventions to mitigate responsive behaviours from resident #006. Staff #132 confirmed that the written plan of care for resident #006 did not identify any responsive behaviours which included identified triggers or any strategies or interventions to help manage the resident's responsive behaviours.

This area of non compliance was identified during a complaint inspection, log #014636-19 conducted currently with this critical incident inspection. [s. 53. (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 residents demonstrating responsive behaviours, behavioural triggers are identified and strategies are developed and implemented to respond to the needs of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

The home submitted a CIS report identifying abuse of resident #001.

A. On an identified date in 2019, PSW #104 was observed providing care to resident #001. The resident demonstrated responsive behaviours during care and the PSW performed an action toward the resident. The PSW proceeded to provide care to the resident and at times the resident demonstrated responsive behaviours and the PSW would respond inappropriately to the resident. Interview with the Administrator confirmed that PSW#104 actions met the definition of abuse towards resident #001.
B. On an identified date in 2019, PSW #108 and #123 were providing care to resident #001. Resident #001 asked for assistance and the PSWs told them they would have to wait. At this time both PSWs continually performed an action. In an interview with the Administrator they confirmed that PSW #108 and #123's actions toward resident #001 met the definition of abuse.
C. On an identified date in 2019, PSW #123 was providing care to resident #001. The resident was displaying responsive behaviours and PSW #123 responded to the resident. Interview with Administrator confirmed the PSW's actions met the definition of abuse.
D. On an identified date in 2019, PSW #109 was observed providing care to resident #001. The PSW performed an action toward the resident and the resident displayed responsive behaviours, the PSW then performed another action toward the resident on several occasions. Interview with the Administrator confirmed that PSW #019's actions towards resident #001 met the definition abuse.
The licensee has failed to protect resident #001 from abuse. [s. 19. (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 resident #001 is protected from abuse by anyone, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 for eating as specified in their plan.

On an identified date in August 2019, the Long Term Care (LTC) homes inspector was observing a medication pass for resident #001. RPN #127 gave the resident their medications and then gave the resident drinks without an assistive device. The resident's plan of care confirmed the resident was to use the assistive at all times. Interview with RPN#127 confirmed they did not follow the resident's plan of care.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 for treatment as specified in their plan.

A. On an identified date in August 2019, the LTC homes inspector observed resident #008 receiving a treatment. A review of the resident's plan of care identified that resident #008 was to use a specified amount of the treatment. A review of the physician's medication review and the most recent order from May 2019, also confirmed that the resident was to use a specified amount of treatment. An interview with RPN #130 confirmed that the resident was using a different amount of the treatment and the resident's plan of care was not followed.

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 for treatment as specified in their plan.

A. On an identified date in August 2019, the LTC homes inspector observed resident #007 to be using a specific amount of treatment and on the next day observed the resident a different amount of the treatment. A review of the resident's plan of care confirmed that the resident was to have the specific treatment as per physician's orders. A review of the physician's medication review and the most recent order from May 2019, also confirmed that the resident was to use a specific amount of the treatment. An interview with RPN #127 confirmed resident #007 was using wrong amount and the resident's plan of care was not followed.

This area of non compliance was identified during a complaint inspection, log #014636-19 conducted currently with this critical incident inspection.

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

The home submitted a CIS report in 2019, identifying inappropriate care of resident #001. Resident #001's plan of care identified that the resident was to have two staff for all care.

A. On an identified date in 2019, PSW #103 was observed providing care by themselves. Resident #001's plan of care specifically stated to use two staff to assist with activities of daily living (ADL's). In an interview with the Administrator on an identified date in July 2019, they confirmed PSW #103 did not follow the resident's plan of care.
B. On an identified date in June 2019, PSW #104 was observed providing care to resident #001 by themselves. In an interview with the Administrator they confirmed PSW #104 did not follow the resident's plan of care.
C. On an identified date in 2019, PSW #109 was observed providing care to resident #001 by themselves. Resident #001's plan of care specifically stated to use two staff for all ADLs. In an interview with the Administrator on an identified date in July 2019, they confirmed PSW #109 did not follow the resident's plan of care.

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 for toileting as specified in their plan.

On an identified date in 2019, it was observed that resident #001 was provided care by PSW #109, it was confirmed that the resident was not checked or provided care again for approximately eight hours. The resident's plan of care specifically stated that the resident was to to have an intervention completed before and after meals. Interview with Administrator confirmed that the resident's plan of care was not followed as the resident was not provided the intervention before or after lunch.

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in their plan.

A complaint was submitted to the Director on an identified date in July 2019, regarding

medication administration. Clinical record review confirmed resident #006 had a physician's order for a medication when to administer it and when to hold it and when they should call the physician.

A. On an identified date in June 2019, resident #006's medication needed to held and the physician was to be notified. A review of the clinical record confirmed that the physician was not called as the order directed. Interview with RN #142 confirmed they did not call the physician as per the resident's medication order.
B. On an identified date in June 2019,resident #006's medication needed to held and the physician was to be notified. A review of the clinical record confirmed that the physician was not called as the order directed. Interview with RN #133 confirmed they did not call the physician as per the resident's medication order.
C. On an identified date in June 2019, resident #006's medication needed to held and the physician was to be notified. A review of the clinical record confirmed that the physician was not called as the order directed. Interview with RN #143 confirmed they did not call the physician as per the resident's medication order.
D. On an identified date in June 2019, resident #006's medication needed to held and the physician was to be notified. A review of the clinical record confirmed that the physician was not called as the order directed. Interview with RN #143 confirmed they did not call the physician as per the resident's medication order.
The licensee failed to ensure that resident #006's plan of care was followed regarding when to call the physician.

This area of non compliance was identified during a complaint inspection, log #014636-19 conducted currently with this critical incident inspection.

7. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided to the resident as per the plan.

The home submitted a CIS report on an identified date in 2019, identifying inappropriate care of resident #001.

Resident #001 had known responsive behaviours, the home had also identified what could potentially trigger these behaviours and had put interventions in place to mitigate these responsive behaviours.

A. On an identified date in 2019, PSW #125 was responding to resident #001's device. PSW #125 came in the room and performed an action and the PSW did not implement

any of the strategies that were identified in the resident's plan of care that were put in place to assist the resident with managing their responsive behaviours.
B. On an identified date in 2019, PSW #106 and PSW #124 were putting resident #001 back to bed. The resident was noted to be continuously displaying responsive behaviours during the whole process. The PSW's did not implement any of the strategies that were identified in the resident's plan of care that were put in place to
assist the resident with managing their responsive behaviours.
C. On an identified date in 2019, PSW #104 was completing care with resident #001. The resident was noted to be displaying responsive behaviours during the entire time and PSW #104 proceeded to complete care without implementing any of the strategies that were identified in the resident's plan of care.
In an interview with the Administrator, they confirmed that home did not implement the strategies listed in the resident's documented plan of care to help manage the resident's responsive behaviours.

A compliance order has been issued for s. 6 (7) prior to this incident inspection report 2019_549107_0007 with a compliance date of October 31, 2019. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received individualized personal care, including hygiene care and grooming on a daily basis.

The home submitted a CIS report July 2019, identifying abuse of resident #001. During conversation with the resident's SDM, they reported that the resident had not received hygiene care.

A. On an identified date in 2019, PSW #103 was observed providing care. The PSW did not provide the specified care. The Administrator confirmed on an identified date in 2019, resident #001 was not provided their full hygiene care.
B. On an identified date in 2019, PSW #103 was observed providing care. The PSW did not provide hygiene care. The Administrator confirmed on an identified date in July 2019, that resident #001 was not provided their full hygiene care. [s. 32.]

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.