Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2019	2019_558123_0011	015523-19	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

MELODY GRAY (123)

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): August 16, 20, 21, 22, 23, 27, 28, 29, September 23, 24, 25, 26 & 27, 2019.

During the course of this inspection, the inspector reviewed the home's records and residents' health records.

During the course of the inspection, the inspector(s) spoke with residents; family members; Personal Support Workers (PSWs); registered staff; the Assistant Directors of Care (ADOCs); the Directors of Care (DOCs); the staff educator; the Human Resources Manager and the Administrator.

The following complaint inspections were conducted concurrently with this inspection:
#016112-19 related to staffing and alleged abuse and neglect and
#016753-19 related to staffing and alleged abuse and neglect.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, s. 6 (7) and a Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 8 (1) (b) were identified during this inspection and have been issued in Inspection Report 2019_558123_0012 / 016112-19, 016753-19, which was conducted concurrently with this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 responses to interventions were documented.

Critical incident (CI) report #2975-000041-19, submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in August 2019, which reported an unexpected death was reviewed. It was noted that on an identified date in August 2019, resident #001 fell. Later that day, there was a change in their health status. Their plan of care indicated they were to have an identified intervention provided; it was not provided to the resident and they passed away.

Personal support worker (PSW) #104 reported that on the identified date in August 2019, they assisted resident #001 with activities of daily living (ADLs). PSW #173, also assisted the resident with ADLs on that day.

The health record of resident #001, including the progress notes and the August 2019, Nursing Flow Sheets were reviewed. The progress notes documentation of the identified date in August 2019, indicated the resident was provided assistance with ADLs. The August 2019, Nursing Flow Sheets were reviewed and there was no documentation of any care/assistance provided to the resident on the identified date in August 2019.

Director of Care (DOC) #101 reported that the resident was provided care and assistance with ADLs on the identified date in August 2019. They reviewed resident #001's August 2019, Nursing Flow Sheets and confirmed that aspects of care and or assistance with ADLs provided to resident #001 on the identified date in August 2019, were not documented as noted above. [s. 30. (2)]

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.