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

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

Public Copy/Copie 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
Nov 22, 2019	2019_661683_0020	010582-19, 011874-19, 012435-19, 012641-19, 012838-19, 015535-19, 015635-19, 016334-19, 016338-19, 017316-19, 017584-19, 018248-19, 020153-19	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

LISA BOS (683), DIANNE BARSEVICH (581), STACEY GUTHRIE (750)

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): October 17, 18, 21, 22, 23,

24, 25, 28, 29, 30, 31, November 1, 4, 5, 6, 7 and 8, 2019.

This inspection was completed concurrently with complaint inspection #2019_661683_0021.

The following intakes were completed during this critical incident inspection:

Log #010582-19 was related to falls prevention and management
Log #012435-19 was related to falls prevention and management
Log #012641-19 was related to falls prevention and management
Log #015535-19 was related to falls prevention and management
Log #015635-19 was related to safe and secure home
Log #016334-19 was related to medication administration
Log #016338-19 was related to falls prevention and management
Log #017316-19 was related to the prevention of abuse and neglect and responsive behaviours
Log #017584-19 was related to falls prevention and management
Log #018248-19 was related to the prevention of abuse and neglect and responsive behaviours
Log #020153-19 was related to the prevention of abuse and neglect and responsive behaviours

The following follow-up inspections were completed concurrently with this critical incident inspection:

Log #011874-19 was related to CO #001 from inspection #2019_570528_0012 regarding O. Reg. 79/10 s. 69
Log #012838-19 was related to CO#001 from inspection #2019_549107_0007 regarding LTCHA, 2007 s. 6 (7)

PLEASE NOTE:
A Written Notification (WN) and a Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 26 (3) 19, identified in a concurrent inspection #2019_661683_0021 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality, Performance Systems and Food Services, the Director(s) of Care (DOC), the Assistant Director(s) of Care (ADOC), the Resident Care Managers

(RCM), the Education, Quality and Clinical Support Lead, the Resident Assessment Instrument (RAI) Coordinator(s), the Human Resources Manager, the Unit Manager, the Physiotherapist (PT), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed internal audits, reviewed the complaints log and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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
O.Reg 79/10 s. 69.	CO #001	2019_570528_0012	683

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. 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 #009 and #010 were protected from physical abuse by anyone.

O. Reg. 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) A Critical Incident (CI) report was submitted to the Director under the category of resident to resident physical abuse. A review of the CI report, staff interviews and a review of the progress notes for residents #009 and #010 indicated that on an identified date, there was an altercation between resident #009 and #010 which resulted in an injury to resident #010.

A review of the progress notes for residents #009 and #010 indicated that there was a previous incident between the two residents and as a result, the home put interventions in place.

A review of the clinical record for resident #009 indicated that they had an identified diagnosis and demonstrated specific behaviours, for which the home initiated various interventions. A review of the clinical record for resident #010 indicated that they had an identified Cognitive Performance Scale (CPS) score and that there was a specific intervention in place related to the resident's safety.

Resident #010 was interviewed regarding the incident and they recalled what happened and indicated that they sustained an injury as a result.

In an interview with Personal Support Worker (PSW) #126, they indicated that they did not witness how the incident started, but they witnessed the positioning of resident #010 as a result of the incident.

In an interview with Registered Practical Nurse (RPN) #151, who responded to the

incident, they indicated that they did not see how it started, but they recalled what they saw when they arrived. They indicated that resident #010 was able to recall what happened and acknowledged that as a result of the incident, there was an injury to resident #010.

In an interview with Director of Care (DOC) #101, they indicated that the incident between the two residents was not witnessed, but resident #010 recalled what happened. Inspector #683 read the above definition of physical abuse to DOC #101 and they acknowledged that resident #010 sustained an injury and that the incident met the definition of physical abuse.

The home did not ensure that resident #010 was protected from physical abuse by resident #009.

B) A CI report was submitted to the Director under the category of resident to resident physical abuse. A review of the CI report indicated that on an identified date, PSW #135 witnessed an altercation between resident #009 and #010, which resulted in an injury to resident #009.

A review of the progress notes for residents #009 and #010 identified that there was a history of behaviours between the two residents. The home initiated various interventions as a result of the incidents to ensure their safety.

A review of the clinical record for resident #009 indicated that they had an identified diagnosis and CPS score. Their written plan of care indicated that they demonstrated specific behaviours, for which the home initiated various interventions. A review of the clinical record for resident #010 indicated that they had an identified CPS score and that there was a potential for behaviours to be displayed by the resident.

In an interview with resident #010, they recalled what happened from their point of view, but acknowledged that they demonstrated a physical behaviour towards resident #009.

In an interview with PSW #135, they indicated that on the identified date, they observed the altercation between the two residents and indicated the outcome of the incident.

In an interview with DOC #101, they acknowledged that the incident resulted in an injury to resident #009.

The home did not ensure that resident #009 was protected from physical abuse by resident #010. [s. 19.]

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 LTCHA, 2007 S.O. 2007, c.8, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (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 has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On two identified dates, resident #003 was observed with an identified fall prevention intervention in place.

Review of the plan of care indicated that the Power of Attorney (POA) was informed and considering the use of the fall prevention intervention.

In an interview with PSW #107, they stated the resident had the fall prevention intervention in place since a specific incident.

During an interview with RCM #106 and review of the plan of care, they stated that the resident had the fall prevention intervention in place daily and confirmed that this intervention was not identified in the written plan of care to manage the resident's falls.

The licensee failed to ensure there was a written plan of care for each resident that set out the planned care for the resident related to falls interventions. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Review of the plan of care indicated that resident #005 had several falls between identified dates that happened in the same area, at a similar time of day. One of the falls resulted in a significant change in the resident's status.

Review of the Physiotherapist (PT) assessment identified they recommended a specific nursing intervention to try and prevent falls for the resident.

Following a review of the plan of care with the PT, they confirmed that the specific nursing intervention that they recommended was not implemented after they recommended it and acknowledged that the resident sustained more falls in the same location at a similar time of day. They indicated the resident's risk level for falls and noted that the resident had a known behaviour which may have contributed to their

falling.

During an interview with RCM #112, after they reviewed the plan of care, they confirmed that the nursing intervention was not implemented after the PT recommended it. They stated that registered staff worked closely with the PT and was not sure why the intervention was not implemented as a falls intervention.

The licensee failed to ensure registered staff collaborated in the development and implementation of the plan of care so that different aspects of care were integrated, consistent with and complemented each other. [s. 6. (4) (b)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Review of the written plan of care for resident #011, under interventions for risk of falls, identified the resident was to have specific interventions in place.

On an identified date, resident #011 was observed and two specific falls prevention interventions were not in place, as per their written plan of care.

During an interview, observation of the resident in bed and review of the Kardex with PSW #127, they confirmed that the resident's fall prevention interventions were not in place, as per their plan of care.

In an interview with Resident Assessment Instrument (RAI) Coordinator #128, after reviewing the written plan of care, they confirmed that the fall prevention interventions should have been in place at the time of the observation.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls interventions.

B) A review of the written plan of care for resident #012, under interventions for risk of falls, identified the resident was to have specific falls prevention interventions in place.

On three dates, the resident's fall prevention interventions were not in place as per their written plan of care.

During interviews with PSW #129 and #130, they confirmed that the fall prevention

interventions were not in place as per the resident's written plan of care.

Inspector #581 and PSW #150 observed the resident, and PSW #150 confirmed that the falls prevention intervention was not in place and it should have been.

In an interview with RAI Coordinator #128, after reviewing the written plan of care, they stated that the fall prevention interventions should have been in place for the resident.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls interventions.

C) Review of the plan of care identified that resident #008 was to have a specific falls prevention intervention in place.

Resident #008 was observed on an identified date and did not have one of their fall prevention interventions in place.

In an interview with PSW #124 they stated the resident was to have the fall prevention intervention in place daily and confirmed it was not put in place that day.

During an interview with RPN #123, after they observed the resident and reviewed the plan of care, they stated the resident was to have the falls prevention intervention in place at specific times and that it was not in place.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to a falls prevention intervention.

D) Review of the plan of care for resident #008 identified that they were to have a specific falls prevention intervention in place. The resident was observed on an identified date and the specific falls prevention intervention was not in place.

During an interview with RPN #134 after they observed the resident and reviewed their plan of care, they acknowledged the intervention was not in place and confirmed that it should have been.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to the falls prevention intervention. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was no longer necessary.

Review of the clinical record identified that staff were to complete specific documentation for resident #014 at identified time intervals.

Following a review of the plan of care with RPN #113, they confirmed that staff no longer completed the documentation for the resident and indicated that the documentation only occurred for an identified time period after a specific incident.

RPN #113 confirmed the plan of care was not reviewed and revised when the resident's care set out in the plan was no longer necessary related to documentation for resident #014. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1 the licensee was required to have an interdisciplinary Falls Prevention and Management program.

Specifically, the licensee failed to comply with the policy, titled "Falls Prevention and Management," policy number: POL/3, which directed under "When a Fall Occurs" that the Head Injury Routine (HIR) would be followed if the resident struck their head, was suspected of striking their head or for an unwitnessed fall where the resident was unable to accurately report whether they hit their head.

The licensee's policy titled "Head Injury Routine," directed that the frequency of head injury routine assessment would be completed every half an hour for the first two hours, every hour for next four hours and then every four hours for the next 24 hours.

A) Review of the clinical health record identified that resident #003 had multiple of falls, one of which resulted in a significant change in status.

Review of the plan of care post fall on an identified date, indicated that the HIR was not initiated.

Review of the plan of care identified that the Head Injury Routine Record was initiated post fall on an identified date; however, was not completed according to the licensee's policy.

During an interview with the RCM #106, they stated it was the licensee's expectation that the HIR would be completed post unwitnessed falls according to the licensee's policy and the assessment would be documented on the HIR Record.

RCM #106 confirmed that the HIR was not initiated after resident #003's fall on an identified date, and that the head injury routine was initiated but not fully completed by the registered staff after resident #003 had a fall on an identified date.

The licensee's HIR policy was not complied with for the falls for resident #003.

B) Review of the plan of care identified that resident #008 fell on identified dates.

Following a review of the plan of care with RPN #125, they confirmed that the HIR record post falls on identified dates was initiated; however, was not fully completed according to the licensee's policy.

During an interview with DOC #101, after they reviewed the plan of care, they confirmed that the HIR record was not initiated post falls on identified dates for resident #008.

The licensee's HIR policy was not complied with post multiple falls for resident #008.

C) Review of the plan of care identified that resident #005 had unwitnessed falls on identified dates.

Following a review of the plan of care with DOC #102, they confirmed the HIR record post falls on the identified dates was initiated; however, was not fully completed according to the licensee's policy.

The licensee's HIR policy was not complied with post falls for resident #005. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 and #014's plan of care was based on, at a minimum, interdisciplinary assessment of the resident's safety risks.

A) A complaint was submitted to the Director in relation to concerns of the safety of resident #001.

A review of the written plan of care for resident #001 indicated their preferences for an identified activity. The resident had an assessment completed upon admission in relation to their safety for the activity, which indicated that they were safe to participate in the activity without supervision. The assessment indicated the resident's preferences for the time of day in which they liked to complete the activity; however, the time of day in which the resident was known to complete the activity was not included in the assessment.

In interviews with PSW #147, PSW #148, RPN #118 and Assistant Director of Care (ADOC) #104, they acknowledged that resident #001 was known to complete the activity at a specific time of day. PSW #147 indicated that the resident was supposed to sign out when they left the home area for the activity, but they did not, and in interviews with PSWs #147, #148, and #149 they indicated that they did not have to complete any monitoring for resident #001 when they were off the home area for the activity.

In an interview with resident #001, they shared that they liked to enjoy the activity at a specific time of day.

In an interview with DOC #102, they indicated that resident #001 was able to make their own decisions related to the activity.

In an interview with RPN #118, they indicated that they were not aware of an assessment completed for resident #001 related to safety risks for the activity. They acknowledged that there was one incident that occurred when the resident was off the home area completing the activity at a specified time of day.

The home did not ensure that resident #001's plan of care was based on interdisciplinary assessment of resident #001's safety risks regarding their choice to complete an identified activity at a specific time of day.

B) A CI report was submitted to the Director related to resident #014 being missing from the home for an identified amount of time. The CI indicated that an incident occurred once the resident had left the home's property.

A review of the plan of care did not identify an interdisciplinary assessment of the safety risks related to the resident leaving the premises.

In an interview with RPN #113, they acknowledged the resident often left the property. They stated the resident was encouraged to tell staff when they were leaving the property; however, this was not enforced, and their casual leave was not always documented. They acknowledged that when the resident left the property, staff on the home area did not always know where they were going, how long they planned to be off site and there were no interventions in place prior to the incident on the identified date, to ensure the resident was safe when they left the home for a casual leave of absence.

In an interview with RCM #112, they confirmed that there was no interdisciplinary assessment of the safety risks related to resident #014 leaving the home's property until an identified date.

The licensee failed to ensure that resident #014's plan of care was based on an interdisciplinary assessment related to safety risks. [s. 26. (3) 19.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the safety risks with respect to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 140. Every licensee of a long-term care home shall ensure that each medical absence, psychiatric absence, casual absence and vacation absence of a resident of the home is recorded. O. Reg. 79/10, s. 140.

Findings/Faits saillants :

1. The licensee has failed to ensure that each casual absence of a resident of the home was documented for resident #014.

Ontario Regulation 79/10 defines a casual absence as an absence of a resident from a long-term care home for a period not exceeding 48 hours for a purpose other than receiving medical or psychiatric care or undergoing medical or psychiatric assessment.

A review of the clinical record identified on an identified date, resident #014 was missing from the home for an identified time period and there was no documentation that indicated that the resident had left the property and was on a casual absence.

During an interview with DOC #102, they stated resident #014 was capable of leaving the home on their own for extended periods of time and often left the property. The resident was encouraged to inform staff when they were leaving the property, sign out on the "Resident Sign Out Sheet;" however, confirmed it was not a requirement of the home for registered staff to record when the resident left, where they were planning to go and when they planned to return to the home after a casual absence.

DOC #102 acknowledged that on an identified date, there were incidents that occurred when the resident left the home. The resident had not signed out nor had the registered staff documented they had left the home for a casual absence.

The licensee failed to ensure that each casual absence was recorded for resident #014 on an identified date. [s. 140.]

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 casual absence of a resident of the home is recorded, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was created and maintained for each resident of the home.

A) Review of the plan of care identified that resident #005 sustained an unwitnessed fall on an identified date.

Review of the progress notes indicated that the HIR was maintained and on an identified date, it was documented that the HIR record was discontinued by the RN.

During an interview with DOC #102, they stated the HIR post fall was documented by the registered staff as being completed; however, confirmed they were unable to find the HIR record in the resident's plan of care.

The written record for the HIR post fall on the identified date was not maintained for resident #005.

B) A review of the clinical record identified that staff were to complete specific documentation for resident #014 at identified time intervals.

Following a review of the plan of care with RPN #113, they confirmed that staff no longer completed the documentation for the resident and indicated that the documentation only occurred for an identified time period after an incident.

In an interview with RPN #113, they stated the documentation was completed by staff at identified time intervals and indicated that the documentation only occurred for an time period after a specific incident.

Following a review of the plan of care, RPN #113 acknowledged they were unable to find the documentation and confirmed that written record was not maintained.

The written record for the identified documentation was not maintained for resident #014. [s. 231. (a)]

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 written record is created and maintained for each resident of the home, to be implemented voluntarily.

WN #7: 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home, no later than one business day after the occurrence of the incident.

A review of the home's medication incident binder for 2019, found a medication incident report for an identified date, regarding a medication that was reported missing for resident #002.

A review of the critical incidents for 2019, did not find a report of the missing medication for resident #002 on the identified date.

In an interview with Registered Nurse (RN) #114, they confirmed that they could not locate the missing medication for resident #002 and they left a note for the oncoming shift. RN #114 was advised later by Unit Manager #117, to complete a medication incident report which was completed with the assistance of the unit manager. RN #114 acknowledged that they documented in point click care indicating the medication was missing and steps taken by the RN, as well as filled out an incident report but no other documentation was completed.

In a follow up discussion with Unit Manager #117, they confirmed that they did not submit a Critical Incident for the missing medication to the Director.

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home, no later than one business day after the occurrence of the incident. [s. 107. (3) 3.]

Issued on this 11th day of December, 2019

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683), DIANNE BARSEVICH (581), STACEY GUTHRIE (750)
Inspection No. / No de l’inspection :	2019_661683_0020
Log No. / No de registre :	010582-19, 011874-19, 012435-19, 012641-19, 012838-19, 015535-19, 015635-19, 016334-19, 016338-19, 017316-19, 017584-19, 018248-19, 020153-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 22, 2019
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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee must:

1. Protect resident #009 and any other resident from abuse by resident #010 or any other resident.

2. Protect resident #010 and any other resident from abuse by resident #009 or any other resident.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #009 and #010 were protected from physical abuse by anyone.

O. Reg. 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) A Critical Incident (CI) report was submitted to the Director under the category of resident to resident physical abuse. A review of the CI report, staff interviews and a review of the progress notes for residents #009 and #010 indicated that on an identified date, there was an altercation between resident #009 and #010 which resulted in an injury to resident #010.

A review of the progress notes for residents #009 and #010 indicated that there was a previous incident between the two residents and as a result, the home put interventions in place.

A review of the clinical record for resident #009 indicated that they had an identified diagnosis and demonstrated specific behaviours, for which the home

initiated various interventions. A review of the clinical record for resident #010 indicated that they had an identified Cognitive Performance Scale (CPS) score and that there was a specific intervention in place related to the resident's safety.

Resident #010 was interviewed regarding the incident and they recalled what happened and indicated that they sustained an injury as a result.

In an interview with Personal Support Worker (PSW) #126, they indicated that they did not witness how the incident started, but they witnessed the positioning of resident #010 as a result of the incident.

In an interview with Registered Practical Nurse (RPN) #151, who responded to the incident, they indicated that they did not see how it started, but they recalled what they saw when they arrived. They indicated that resident #010 was able to recall what happened and acknowledged that as a result of the incident, there was an injury to resident #010.

In an interview with Director of Care (DOC) #101, they indicated that the incident between the two residents was not witnessed, but resident #010 recalled what happened. Inspector #683 read the above definition of physical abuse to DOC #101 and they acknowledged that resident #010 sustained an injury and that the incident met the definition of physical abuse.

The home did not ensure that resident #010 was protected from physical abuse by resident #009.

B) A CI report was submitted to the Director under the category of resident to resident physical abuse. A review of the CI report indicated that on an identified date, PSW #135 witnessed an altercation between resident #009 and #010, which resulted in an injury to resident #009.

A review of the progress notes for residents #009 and #010 identified that there was a history of behaviours between the two residents. The home initiated various interventions as a result of the incidents to ensure their safety.

A review of the clinical record for resident #009 indicated that they had an

identified diagnosis and CPS score. Their written plan of care indicated that they demonstrated specific behaviours, for which the home initiated various interventions. A review of the clinical record for resident #010 indicated that they had an identified CPS score and that there was a potential for behaviours to be displayed by the resident.

In an interview with resident #010, they recalled what happened from their point of view, but acknowledged that they demonstrated a physical behaviour towards resident #009.

In an interview with PSW #135, they indicated that on the identified date, they observed the altercation between the two residents and indicated the outcome of the incident.

In an interview with DOC #101, they acknowledged that the incident resulted in an injury to resident #009.

The home did not ensure that resident #009 was protected from physical abuse by resident #010.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it was related to two of three residents reviewed. The home had a level 3 compliance history as they had one or more non-compliances, one of which was the same subsection that included:

• Voluntary plan of correction (VPC) issued August 20, 2019 (2019_555506_0005);
• Compliance order (CO) #001 issued July 13, 2018, with a compliance due date of August 7, 2018 (2018_689586_0014);
• CO #002 issued October 11, 2017, with a compliance due date of January 11, 2018 (2017_690130_0001);
• Written notification (WN) issued October 26, 2017 (2017_542511_0011);
• CO #001 issued March 3, 2017, with a compliance due date of May 30, 2017 (2017_57610a_0002). (683)

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 : Feb 28, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_549107_0007, CO #001;

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 :

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

Specifically, the licensee must:

1. Ensure that resident #008, #011, #012, and all other residents, are provided with their fall prevention interventions, as per their plan of care.

2. Develop an auditing tool to determine if fall prevention interventions are in place for residents #008, #011 and #012 as per their plan of care. The audit must identify, but is not limited to, the specific fall prevention interventions that residents #008, #011 and #012 require, as per their plan of care. The audit must indicate whether the identified fall prevention interventions were in place for the identified residents at the time of the audit, and any corrective actions taken if the identified interventions were not in place. Records are to be maintained of the audits, which are to be completed, at a minimum, monthly.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection # 2019_549107_0007 (A1) issued July 3, 2019, with a compliance date of October 31, 2019. The licensee was ordered to be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee was ordered to:
a) Ensure resident #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 one to one monitoring required as per the plan of care.
c) Conduct an audit, at a schedule of the home's choosing, to ensure that the falls prevention and one to one interventions are provided to residents as specified in their plan of care.
d) Keep a documented record of the audit.

The licensee completed steps b), c) and d).
The licensee failed to complete step a).

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Review of the written plan of care for resident #011, under interventions for risk of falls, identified the resident was to have specific interventions in place.

On an identified date, resident #011 was observed and two specific falls prevention interventions were not in place, as per their written plan of care.

During an interview, observation of the resident in bed and review of the Kardex with PSW #127, they confirmed that the resident's fall prevention interventions were not in place, as per their plan of care.

In an interview with Resident Assessment Instrument (RAI) Coordinator #128, after reviewing the written plan of care, they confirmed that the fall prevention interventions should have been in place at the time of the observation.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls interventions.

B) A review of the written plan of care for resident #012, under interventions for risk of falls, identified the resident was to have specific falls prevention interventions in place.

On three dates, the resident's fall prevention interventions were not in place as per their written plan of care.

During interviews with PSW #129 and #130, they confirmed that the fall prevention interventions were not in place as per the resident's written plan of care.

Inspector #581 and PSW #150 observed the resident, and PSW #150 confirmed that the falls prevention intervention was not in place and it should have been.

In an interview with RAI Coordinator #128, after reviewing the written plan of care, they stated that the fall prevention interventions should have been in place for the resident.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls interventions.

C) Review of the plan of care identified that resident #008 was to have a specific falls prevention intervention in place.

Resident #008 was observed on an identified date and did not have one of their fall prevention interventions in place.

In an interview with PSW #124 they stated the resident was to have the fall prevention intervention in place daily and confirmed it was not put in place that day.

During an interview with RPN #123, after they observed the resident and reviewed the plan of care, they stated the resident was to have the falls prevention intervention in place at specific times and that it was not in place.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to a falls prevention intervention.

D) Review of the plan of care for resident #008 identified that they were to have a specific falls prevention intervention in place. The resident was observed on an identified date and the specific falls prevention intervention was not in place.

During an interview with RPN #134 after they observed the resident and

reviewed their plan of care, they acknowledged the intervention was not in place and confirmed that it should have been.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to the falls prevention intervention.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it was related to three of three residents reviewed. The home had a level 5 compliance history as a compliance order was being re-issued related to the same subsection and they had four or more compliance orders (complied or not; same or different) that included:

• Written notification (WN) issued October 25, 2019 (2019_560632_0020);
• WN issued August 20, 2019 (2019_555506_0005);
• Compliance order (CO) #001 issued July 3, 2019, with a compliance due date of October 31, 2019 (2019_549107_0007);
• CO #002 issued October 26, 2017, with a compliance due date of December 8, 2017 (2017_542511_0011);
• Voluntary plan of correction (VPC) issued April 4, 2017 (2017_57610a_0005). (581)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 20, 2020

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

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 22nd day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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