Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ministère des Soins de longue durée
Division des opérations de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Pamela Chou
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 X Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	Inspection #: **2019 560632 0020 A1**
Licensee:	St. Joseph's Health System
LTC Home:	St. Joseph's Villa, Dundas
Name of Administrator:	Mieke Ewen, Administrator

Background:
Ministry of Long-Term Care (MLTC) Inspectors #632, #748, #586, and #123 conducted a Complaint inspection at St. Joseph's Villa, Dundas (the home) on the following dates: August 20, 21, 22, 23, 26, 27, 28, 29, 30, September 3, 4,5, 6, 10, 11, 12, 13, 16, 17, 24, 25, 26, 27, 2019 (Inspection #: 2019_560632_0020 (A1)). During the inspection, intake logs #016112-19 and #016753-19 were inspected concurrently. In addition, Critical Incident Inspection #2019_558123_0011 was also concurrently completed related to intake log #015523-19. As part of the inspection, the inspectors found the Licensee, St. Joseph's Health System (the Licensee), failed to comply with s. 20 (1) of the Long-Term Care Homes Act, 2007 (the *Act*) and issued Compliance Order #005.

Pursuant to s. 153(1)(a) of the *LTCHA*, Inspector #123 issued the following Orders:

Compliance Order #005 relates to s. 20 (1) of the *LTCHA* and reads as follows:

The licensee must be compliant with LTCHA, 2007, s. 20 (1).

Specifically, the licensee must:

1) Notify residents and/or their SDMs of every alleged, suspected or witnessed incident of abuse and or neglect of a resident by the licensee or staff.
2) Immediately investigate every alleged, suspected or witnessed abuse and or neglect of a resident
3) Ensure where the licensee has reasonable grounds to suspect that abuse and or neglect of a resident has occurred or may occur the suspicion and the information upon which it is based is immediately reported to the Director MOHLTC.

The order must be complied with by April 20, 2020.

Following a review of the Inspector's Order #005 by the Director, this order has been altered and substituted with the Director's Order below.

Compliance Order #006 relates to s. 131 (1) of the *LTCHA* and reads as follows:

The licensee must be compliant with O. Reg. 79/19, s. 131. (1) of the LTCHA.

Specifically, the licensee must:

1) Ensure that no drugs are used by or administered to residents' #021, #053, #075, #078 and all other residents, unless the drugs have been prescribed for them.
2) Ensure that drugs are administered to residents' #021, #053, #075, #078 and all other residents in accordance with the directions for use specified by their prescriber.

The order must be complied with by November 29, 2019 (A1).

Following a review of the Inspector's Order #006 by the Director, this order has been altered and substituted with the Director's Order below.

Order:	CO #005

To **St. Joseph's Health System**., you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:

Compliance Order #005 relates to s. 24 (1) of the *LTCHA* and reads as follows:

Reporting certain matters to Director

24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the *Local Health System Integration Act, 2006* or the *Connecting Care Act, 2019*.

Vicariously liable

152 (2) Where an inspector finds that a staff member has not complied with subsection 24 (1) or 26 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Order:

The Licensee must be compliant with s. 24 (1) of the *LTCHA*.

Specifically, the Licensee shall ensure the following:

1) Where the licensee has reasonable grounds to suspect that improper or incompetent treatment and/or abuse or neglect of a resident has occurred or may occur, the Licensee shall immediately report the suspicion and the information upon which it is based to the Director.

2) All staff must follow the home's process for reporting under the home's policy on Prevention of Abuse/Neglect of a Resident.

3) All staff should receive training on the home's policy on Prevention of Abuse/Neglect of a Resident, specifically the process for reporting to the Director.

This order shall be complied by April 20, 2020.

Grounds:

The Licensee has failed to ensure that they have complied with paragraph 1 and paragraph 2 of section 24 (1) of the *LTCHA* related to reporting certain matters to Director.

Section 24 (1) paragraph 1 and 2 of the *LTCHA* states that **"**a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

Furthermore, section 152 (2) of the *LTCHA* states that "where an inspector finds that a staff member has not complied with subsection 24 (1) or 26 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate."

As per section 5 of the *Regulation*, the definition for neglect means "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

On a specified date in August 2019, the Administrator received an email from a union representative regarding a list of staff shifts that were identified as workload issues. The Administrator was away from the office and did not see this information until the Administrator's return to office on a subsequent date in August 2019. This list consisted multiple entries of workload issues ranging across a four-month period during summer of 2019. Within this email, there was communication indicating reasonable grounds to suspect improper care and/or neglect of residents, such as alleged incidents where residents are being left in the bed, not being fed properly, not receiving fluid or nourishments, not being bathed, not receiving medication on time, and not receiving treatments.

On a specified date in August 2019, a union representative sent an email to the President of St. Joseph's Villa, Dundas, which included a list of staff shifts that were identified as workload issues. The email message further contained communication indicating reasonable grounds to suspect improper care and/or neglect of residents.

On a specified date in August 2019, the Administrator received an email from the media, which also included a list of staff shifts that were identified as workload issues. This list consisted of multiple entries

of workload issues ranging across a four-month period during summer of 2019. This list included some additional entries than the list that was sent earlier in August 2019. Within this subsequent list there were entries that suggest potential for improper care and/or neglect.

During the interview with the Inspector, the Administrator indicated that they did receive information from the media on a specified date in August 2019. The Administrator indicated they requested the detailed forms from the union in mid August but did not receive the detailed workload forms until late August 2019. The Administrator also indicated to the Inspector that if the staff have issues, the staff are to go to the manager and the manager should immediately respond and address the problem.

Upon reviewing the detailed workload forms, there are multiple forms that contained reasonable grounds to suspect neglect and/or improper care. Specifically, multiple forms completed by different staff indicated that baths, showers, nourishments, snacks, treatments, and toileting were missed. There are also indications across various forms that residents did not receive pain assessments, received wrong medications, improper care, accidents happening, some residents are neglected, and lack of quality care.

Section 2.0 of the home's policy on *Prevention of Abuse/Neglect of a Resident* indicates that any concern or evidence regarding abuse/neglect, witnessed or suspected, must be reported immediately to the department manager, admin on call (if after business hours), Department Director and the resident's substitute decision maker/first contact. However, a number of the forms that indicated reasonable grounds to suspect neglect and/or improper care, did not have the text field for "Name/Title of Immediate Supervisor Notified" completed. It is unknown if appropriate management were notified despite that staff were completing the workload forms for the union. It is also unknown if the staff are aware of the appropriate reporting process of any witnessed or suspected neglect and if staff are aware of the reporting requirements as per s. 24 (1) of the *LTCHA*.

The list of staff shifts and the email messages that were sent on two separate dates in August and the completed workload forms contained reasonable grounds to suspect neglect and improper care. However, the ministry did not receive any mandatory reports as per s. 24 (1) of the *LTCHA* through its Critical Incident System (CIS) reporting for any of the areas of suspected neglect or improper care. The ministry only received a complaint on August 15, 2019; however, the main reason for this complaint was related to staffing shortages.

The home failed to ensure that its duty to report certain matters to the Director under s. 24 (1) of the *LTCHA* was complied with.

The order is made up on the application of the factors for severity, scope, and compliance history and only these factors. The severity of the non-compliance is minimal harm or minimal risk of harm, the scope of the non-compliance is widespread as the situation has the potential to affect a large number of the home's residents, and the home had a previous non-compliance to the same subsection (WN and VPC) issued on August 10, 2018 (2018_689586_0014).

This order must be complied with by:	April 20, 2020

Order:	CO #006

To **St. Joseph's Health System**., you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:

Compliance Order #006 relates to s. 131 (1) of the *LTCHA* and reads as follows:

Administration of drugs

131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Order:

The Licensee must be compliant with O. Reg 79/10, s. 131 (1) of the *LTCHA*.

Specifically, the Licensee must:

1) Ensure that no drugs are used by or administered to residents #021, #053, #075, #078 and all other residents, unless the drugs have been prescribed for them.

This order shall be complied by Nov 29, 2020.

Grounds:

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Complaint log #016112-19 (IL-69698-HA) submitted to the MLTC identified concerns that the home had a shortage of registered staff working on multiple shifts across a four-month period during summer 2019.

A. The home's Medication Incident reports and the incident notes submitted by the Licensee were reviewed. It was noted that on an identified date in June 2019, RN #178 gave the wrong medication to resident #021. It was noted that the resident and the resident's Substitute Decision-Maker (SDM) were notified of the incident. Interventions were provided and the resident was monitored.

The licensee failed to ensure that no drug was used by resident #021 unless the drug had been prescribed for the resident.

B. The home's Medication Incident reports and the incident notes submitted by the Licensee were

reviewed. It was noted that on an identified date in June 2019, RPN #161 administered the wrong medications to resident #053. The medications of resident #075 were administered to resident #053 in error. The resident, the resident's SDM and the physician were notified of the incident. The physician gave orders that the resident's vital signs were to be checked frequently and their health status was to be monitored.

The licensee failed to ensure that no drug was administered to resident #053 unless the drug was prescribed for the resident.

C. The home's Medication Incident records and the incident notes submitted by the Licensee were reviewed. It was noted that on an identified date in May 2019, RN #177 administered the wrong medication to resident #078. The resident, the resident's SDM and the Medical Director were notified of the incident. The physician gave orders to monitor the resident's blood pressure and heart rate.

The licensee failed to ensure that medications were administered to resident #078 unless the drug was prescribed for the resident.

The order is made up on the application of the factors for severity, scope, and compliance history and only these factors. The severity of the non-compliance is minimal harm or minimal risk of harm, the scope of the non-compliance is widespread, and the home had a previous non-compliance to the same subsection (WN and VPC) issued on October 26, 2017 (2017_542511_0011).

This order must be complied with by:	December 27, 2019

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4
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.

Issued on this 19th day of December, 2019.	
Signature of Director:	
Name of Director:	Pamela Chou