Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jul 24, 2020	2020_661683_0008	021447-19, 021448-19, 023434-19, 023435-19, 001701-20, 001913-20, 003012-20, 003349-20, 003350-20, 003378-20, 003848-20, 004689-20, 008052-20, 008718-20, 009448-20, 010272-20, 010560-20	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), JESSICA PALADINO (586), 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): May 19, 20, 21, 22, 25, 26, 27, 28, 29, June 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, July 2 and 3, 2020, as both an off-site and on-site inspection.

This inspection was completed concurrently with Complaint Inspection #2020_661683_0009 and Director Order Follow Up inspection #2020_661683_0010.

The following intakes were completed during this critical incident inspection:
Log #001701-20 was related to falls prevention and management
Log #001913-20 was related to falls prevention and management
Log #003012-20 was related to responsive behaviours
Log #003848-20 was related to falls prevention and management
Log #004689-20 was related to falls prevention and management
Log #008052-20 was related to responsive behaviours
Log #008718-20 was related to the prevention of abuse and neglect
Log #009448-20 was related to falls prevention and management and hospitalization and change in condition
Log #010272-20 was related to falls prevention and management
Log #010560-20 was related to falls prevention and management

The following follow up inspections were completed concurrently with this critical incident inspection:
Log #021447-19 was related to CO #002 from inspection #2019_560632_0020 regarding O. Reg. 79/10 s. 71 (3)
Log #021448-19 was related to CO #001 from inspection #2019_560632_0020 regarding O. Reg. 79/10 s. 36
Log #023434-19 was related to CO #001 from inspection #2019_661683_0020 regarding LTCHA s. 19 (1)
Log #023435-19 was related to CO #002 from inspection #2019_661683_0020 regarding LTCHA s. 6 (7)
Log #003349-20 was related to CO #001 from inspection #2020_661683_0001 regarding O. Reg. 79/10 s. 131 (2)
Log #003350-20 was related to CO #002 from inspection #2020_661683_0001 regarding O. Reg. 79/10 s. 135 (1)
Log #003378-20 was related to CO #001 from inspection #2020_661683_0002 regarding LTCHA s. 6 (10)

PLEASE NOTE:
A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 8. (1) (b), and a WN and Compliance Order (CO) related to LTCHA s. 19. (1) , O. Reg. 79/10 s. 36. and O. Reg. 79/10 s. 49. (2), identified in concurrent inspection #2020_661683_0009 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director(s) of Care (DOC), the Assistant Director(s) of Care (ADOC), the Resident Care Managers (RCM), the Physiotherapist (PT), the Pharmacy Manager, Recreational Therapists, 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 and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **5 CO(s)**
- **2 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. 135. (1)	CO #002	2020_661683_0001	506
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2020_661683_0002	683
O.Reg 79/10 s. 71. (3)	CO #002	2019_560632_0020	586

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #002 and #021 as specified in the plan.

A) A Critical Incident (CI) report was submitted to the Director under the category of unexpected death for resident #002.

A review of the resident's clinical record, the CI report and the home's investigation notes identified that PSW #106 gave resident #002 something to eat and shortly after, the resident had a change in condition, so they notified Registered Practical Nurse (RPN) #105.

In an interview with RPN #105 and according to their written statement, they indicated that at an identified time, they walked past the resident and they appeared well. They assessed the resident and then performed an intervention. They indicated that a pulse was absent and they called Registered Nurse (RN) #104.

A review of documentation by RN #104 indicated that when they arrived on scene, the resident's death was pronounced. They documented that the resident was a full code, but noted that when they arrived on the unit, the resident already passed and Cardio-Pulmonary Resuscitation (CPR) would have been no benefit.

i. A review of the resident's written plan of care in place at the time of the incident indicated that they required a specific food and fluid consistency related to an identified diagnosis and there were various interventions in place related to eating.

In an interview with PSW #106 they indicated that they were aware of the appropriate fluid consistency for the resident, and as per the home's investigation notes, they were unaware of the appropriate food consistency for the resident.

In an interview with DOC #102, they acknowledged that the food item provided to resident #002 was not appropriate, as per their plan of care.

The home did not ensure that resident #002 was provided with the appropriate diet texture, as per their plan of care.

ii. Resident #002's advance care planning document was reviewed, and it identified that they wished for CPR for witnessed arrest.

A review of the licensee's policy titled "Code Blue," last updated April 15, 2020, identified that the purpose of a Code Blue for CPR was to achieve the prompt restoration of

effective circulation and respiration in residents suffering a cardiac event. Where appropriate or based on the advanced plan of care of an individual resident, certified staff were to initiate CPR until emergency/ambulance personnel arrived. The policy indicated that CPR was initiated at St. Joseph's Villa for an actual witnessed cardiac arrest in the absence of a Do Not Resuscitate (DNR) order, or in the absence of an expressed wish not to be resuscitated.
The guideline identified the following:

-The arrest should have been witnessed by a reliable observer, or where able to determine that the arrest has occurred within minutes of when the resident was last seen functioning normally (Health Professionals must use clinical judgement to determine whether to proceed with CPR taking into account signs such as: absence of vital signs, skin discolouration, lividity, fixed stare, corneal opacfication, rigor mortis).

-The event should have been unexpected, given the clinical situation.

-The resident should not be suffering from a complex multi-system medical problem that has been shown not to benefit from CPR. This would have been determined by the team as part of the treatment plan.

-The resident clearly does not have an illness for which death would be the expected outcome.

The home did not ensure that CPR was provided to resident #002 as per their wishes specified in their plan of care.

B) According to CI #2976-000017-20, on an identified date, there was an altercation between resident #021 and resident #022.

Resident #021's plan of care directed staff to refer to the resident's safety plan in place, which outlined the use of a specific intervention due to an increase in responsive behaviours.

A progress note indicated that resident #022 was negatively effected by resident #021. The unit staff were informed of this and interventions were put into place. Another progress note from the same date indicated that resident #021 was demonstrating behaviours towards resident #022, causing resident #022 harm.

In an interview with staff #118, PSW #112 and PSW #121, they stated the safety intervention was not in place as required in the plan of care.

Resident #021's plan of care was not followed in regard to their safety plan, resulting in an altercation toward resident #022 causing harm (586). [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 #003 and #025.

A) The home's policy number POL-05 titled "Resident Handling - Lifts, Transfers and Repositioning," last revised November 26, 2019, identified that it was the responsibility of the employer to ensure that all staff complied with the philosophy of a minimal lift facility. The policy identified that staff were to adhere to the designated lift/transfer status as identified on each resident's care plan and for the safety of both the resident and staff, only the designated transfer method was to be used.

i. Review of the clinical health record identified that resident #003 had a fall on an identified date and was manually lifted off the floor.

Review of a note documented by the Physiotherapist indicated that the resident was reassessed, and they required a mechanical lift for transfers.

Following a review of the plan of care and interview with DOC #102, they confirmed the

home had a minimal lift policy in place and residents that had been assessed as a mechanical lift for transfers were to be transferred from the floor with a mechanical lift.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

ii. Review of the clinical health record indicated that resident #003 fell on an identified date, and they were manually lifted off the floor.

A review of a note documented by the Physiotherapist indicated that the resident was to be transferred with a mechanical lift for all transfers.

During an interview with the DOC #102, they confirmed the resident was transferred off the floor with a manual transfer by staff and stated a mechanical lift should have been used.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

iii. On an identified date, resident #003 sustained a fall and was transferred off the floor with a manual lift.

Review of a note documented by the Physiotherapist indicated that the resident was reassessed, and they required a mechanical lift for transfers.

Following an interview and review of the plan of care with DOC #102, they acknowledged that the resident was to be transferred with a mechanical lift for all transfers and should not have been transferred off the floor manually by staff.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

The licensee failed to ensure staff used safe transferring techniques when resident #003 was manually lifted off the floor post three falls.

B) A complaint was submitted to the Director regarding the improper care of resident #025.

Resident #025 resided at St. Joseph's Villa for an identified period of time. A review of their written plan of care in place at the time of the incident identified that they required a mechanical lift for transfers and they were non-weight bearing. The home received a call regarding the complaint about the care of the resident and the home initiated an internal investigation. Seven days later, ADOC #123 was contacted and notified of a significant change in the resident's status. As per the home's amended CIS report, their internal investigation revealed that the resident had a fall that was not documented.

A review of the home's internal investigation notes indicated that on an identified date, PSW #132 went to transfer resident #025, but they could not locate any documentation of their transfer status and they did not receive assistance from RPN #134 in finding the information. They indicated that they transferred the resident with the assistance of PSW #133 using a non mechanical type of transfer. They indicated that instead of immediately notifying the registered staff, they used a mechanical lift to get the resident up off the floor and later reported the fall to registered staff.

In an interview with DOC #101, they acknowledged that PSW #132 and #133 did not use safe transferring techniques for resident #025, which resulted in a fall. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents #003, #004 and #025 fell a post-fall assessment was conducted using a clinically appropriate assessment instrument that

was specifically designed for falls.

The home's policy number POL-03, titled "Falls Prevention Management Program," last revised December 24, 2019, defined a fall as "an event that results in a person coming to rest inadvertently on the ground or floor or other lower level."

The policy indicated that a fall was considered:
-when a resident lost his/her balance and would have fallen if staff did not intervene;
-if the fall resulted in injury;
-if a resident was found on the floor, and staff could not definitively rule out a fall, it was to be considered a fall;
-the distance to the next lower surface is not a factor. If a resident rolls onto the floor from a mattress placed on the floor, it is still a fall.

A) Review of the clinical health record identified in a progress note documented by RPN #155 that on an identified date, resident #003 sustained a fall.

Review of the plan of care identified that a post fall assessment was not completed.

Following an interview and review of the plan of care with DOC #102 they stated that any change in surface level was a fall and a post fall assessment should have been completed by registered staff.

DOC #102 confirmed that a post fall assessment was not completed using a clinically appropriate assessment instrument by registered staff when the resident was found on the floor.

B) A review of a progress note documented in resident #004’s clinical health record indicated that on an identified date, they sustained a fall. RPN #107 assessed the resident and completed a post fall assessment. RPN #107 then documented later that they went to locate the resident and found them on the floor again.

Review of the clinical record identified that a post fall assessment was not completed after the second fall.

Following an interview and review of the plan of care with DOC #102, they acknowledged that a post fall assessment was not completed using the licensee’s post fall assessment tool and confirmed that it was their expectation that staff completed a Fall Incident

electronic document when residents fall.

C) A complaint was submitted to the Director regarding the improper care of resident #025.

A review of the home's internal investigation notes indicated that on an identified date, resident #025 had an undocumented fall when PSWs #132 and #133 completed an unsafe transfer.

A review of the resident's clinical record did not identify a post fall assessment for their fall.

In an interview with PSW #132 and as per the home's investigation notes, they reported that they did not notify RPN #134 when the resident was on the floor. Instead, the resident was transferred up off the floor and the registered staff was later notified about the fall.

In an interview with RPN #134 and as per the home's investigation notes, they indicated that they did not recall PSW #132 reporting a fall for resident #025 to them, therefore they did not assess the resident.

The home did not ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (683) [s. 49. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

A review of resident #012's clinical record identified they had an order for a medication three times daily. On an identified date, documentation indicated that resident #012 received an extra dose of the medication. The medication incident binder was reviewed, and a medication incident report was submitted for the identified date, indicating that resident #012 received an extra dose of the medication as well as their regular scheduled dose. Documentation confirmed that the physician was contacted, and heightened monitoring was ordered to ensure there was no harm to the resident. Interview with RPN #116 confirmed that the resident requested to have an extra dose of the medication. The RPN confirmed that the resident did not receive the correct dose of the medication.

A review of resident #012's clinical record indicated on an identified date, they did not receive a dose of a medication, but it was documented as given. The medication incident binder was reviewed, and a medication incident report was submitted, indicating that resident #012 did not receive their medication as ordered. Documentation indicated that the resident required extra monitoring but did not result in any harm to the resident. Interview with RPN #115 confirmed that they did not dispense the medication from the correct location and confirmed that the resident did not receive their medication as prescribed.

An interview with DOC #101 confirmed that on these two dates the resident did not receive their medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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 resident #029 was protected from abuse.

According to CI report #2975-000023-20, while Personal Support Worker (PSW) #139 was providing care to resident #029, it resulted in harm to the resident.

This information was confirmed through record review of the home's internal investigation notes and the resident's health record, as well as interviews with DOC #102 and PSW #139. DOC #102 confirmed that this met the definition of abuse.

Resident #029 was not protected from abuse by PSW #139 resulting in harm. [s. 19. (1)]

2. The licensee has failed to ensure that resident #025 was not neglected by the licensee or staff.

O. Reg. 79/10, s. 5. defines neglect as “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.”

A complaint was submitted to the Director regarding the improper care of resident #025.

i. Review of the clinical health record for resident #025 identified that they resided at St. Joseph's Villa for a period of time. On an identified date, ADOC #125 was notified of a concern regarding the care of the resident. An investigation was initiated.

ii. On an identified date, ADOC #123 was contacted about a significant change in the resident's status. A CI report was initiated by the home, the police were notified, and the home continued their investigation.

iii. A review of the home's internal investigation notes substantiated that the resident had

an undocumented fall, as a result of an unsafe transfer. Specifically, the investigation notes indicated that on an identified date, PSW #132 went to transfer resident #025, but they could not locate any documentation of their transfer status and they did not receive assistance from RPN #134 in finding the information. With PSW #133, an unsafe transfer was used to move the resident, resulting in a fall. They indicated that instead of immediately notifying the registered staff, they used a mechanical lift to get the resident up off the floor and later reported the fall to registered staff.

iv. A review of the clinical record for resident #025 identified that at the time of the incident, they required a mechanical lift for all transfers. There was no post fall assessment identified for this fall.

v. In an interview with RPN #134, they confirmed that they did not disclose the transfer status or assist the PSW staff in finding the transfer status of the resident. They indicated that a post fall assessment was not completed.

The home demonstrated a pattern of inaction which jeopardized the health, safety and well-being of resident #025 when RPN #134 failed to assist PSW #132 in locating the resident's transfer status, when the PSWs completed an unsafe transfer which resulted in a fall for the resident, when the PSWs failed to immediately notify the registered staff of the fall and transferred them up off the floor without being assessed, and when a post fall assessment was not completed. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was 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 their policy number POL-3, titled "Falls Prevention Management Program," last revised on December 24, 2019, which directed under “At the Time of the Fall,” 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," last revised on April 15, 2020, directed under “Frequency of Assessment,” the HIR 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) A CI report was submitted to the Director under the category of unexpected death for resident #002. A review of the resident's clinical record, the CI report and the home's investigation notes identified that they had two unwitnessed falls.

A review of the HIR record for the resident's fall indicated that the initial HIR assessment was completed; however, was not completed every half hour for the first two hours and there were no further HIR assessments completed until they sustained their second fall.

In an interview with DOC #102, they acknowledged that three sets of vitals were missed within the first two hours after the resident's fall, and that the HIR assessments were not completed, as per the home's Head Injury Routine policy.

The home did not ensure that HIR was completed every half hour for the first two hours after resident #002's fall, as per their HIR policy.

B) Review of the clinical health record identified that resident #003 had three unwitnessed falls, two of which resulted in injury.

i. Review of the plan of care identified that the HIR was initiated after the resident's first fall; however, was not completed every half hour for the first two hours and every hour for the next four hours as confirmed by the DOC #102.

ii. Review of the plan of care identified that the HIR was not initiated after the resident's second fall, as the registered staff continued to document the HIR every four hours from the previous fall. A new HIR record was not initiated after the resident's second unwitnessed fall.

During an interview with DOC #102 they confirmed that registered staff should have implemented a new HIR record post unwitnessed fall according to their Falls Prevention and Management Program and HIR policies.

iii. After the resident's third unwitnessed fall, registered staff initiated the HIR assessment; however, did not complete it according to the licensee's policy.

Following an interview and review of the HIR record with DOC #102 they confirmed that the HIR was not completed according to the licensee's HIR policy.

The licensee's HIR policy was not complied with after resident #003's three unwitnessed falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10, s. 114. (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy number 8-5, titled

"Documentation and Record Keeping Policy, Prescriber's Medication Review," last revised March 2018, in the Pharmacy Manual. This states that all orders must be reviewed by the prescriber, every three months. Any orders not included on the 'Medication Review', once it is signed by the prescriber, are automatically discontinued and the completed 'Medication Review' authorizes the pharmacy to dispense the medication and the nurse to administer the medication for 3 months.

The Procedure for the Medication review is as follows:

A. Precheck Prior to Prescriber Review
1. Check orders on the 'Medication Review' against the prescriber's orders in the resident's chart going back to the date on which the Medication Administration Record (MAR) sheets were last checked against the prescriber's orders.
2. Update the 'Medication Review' form by making all changes necessary to reflect all current prescriber's orders.
3. Continue to add new orders until Prescriber signs.

B. Prescriber Review and Signing
1. Prescriber reviews each order and indicates whether the orders are to be continued or discontinued by initialing or placing a check mark in the "RENEW" or "STOP" column.

C. Processing the 'Medication Review' form
1. Review each individual order and process discontinued or changed orders.
2. New orders on Prescribers Order forms are processed as per home policy.
3. Fax all completed medication reviews to pharmacy along with fax cover page indicating number of pages sent to ensure none are missed.
4. Second nurse verifies all orders are processed completely and accurately and signs and dates at the next "Nurse Signature" line.

A review of resident #012's clinical record identified that there were discrepancies on their medication review that was completed by the Physician and the current MAR.

It was noted that the medication review was printed by the pharmacy and sent to the home on an identified date.

After that date, a medication change occurred, to decrease the dosage of one medication and a new medication was ordered as well.

On an identified date, RPN #136 completed the first step of the medication review and was to check orders on the medication review against the prescribers order back to the date on which the MAR sheets were last checked against the prescriber's orders from the last three month medication review.

On an identified date, as part B of the medication review procedure was signed by the physician and ordered renewal of one medication, another medication was not included on the medication review.

The electronic medication administration record (eMAR) was reviewed, and indicated that the resident was to receive two identified medications at specific doses.

An interview with DOC #101 confirmed that these orders should have been transcribed onto the medication review for the physician to renew. An interview with RPN #136, who completed part A of the medication review, confirmed that they follow the procedure for the medication review; however, at that time they confirmed that they were behind and they missed adding the medications that were changed or newly ordered to the medication review. An interview with RPN #137 confirmed that they also missed the changes when they processed the completed medication review as part C of the procedure.

An interview with DOC #101 confirmed that the policy for medication review was not followed as medication changes and orders were not added to the medication review as per the policy. [s. 8. (1) (b)]

3. 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 their policy number POL-3, titled "Falls Prevention Management Program," last revised on December 24, 2019, which defined a fall as an event that resulted in a person coming to rest inadvertently on the ground or floor or other lower level. The policy defined a near-miss fall as an event where a fall would have likely occurred, without staff intervention and identified that a near-miss fall was considered when a staff member guided a resident to the floor, in order to prevent a fall and/or serious injury.

At the time of the fall, staff were to do the following:
-Notify the RN/RPN on duty, and if possible, stay with the resident to ensure they

remained as comfortable as possible.
-the RN/RPN was to perform a head to toe assessment of every resident after they fell before moving the resident. They were to assess for skin traumas, eg. Skin tears, bruising, lacerations, hematomas, etc. as well as any changes in cognition, changes in range of motion or physical ability and any deformities that were indicative of a fracture.
-After assessment by RN/RPN, staff were to determine the safest method to be used to ambulate or transfer the resident from the fall location.

A complaint was submitted to the Director regarding the improper care of resident #025.

A review of the home's internal investigation notes indicated that on an identified date, resident #025 had an undocumented fall when PSWs #132 and #133 completed an unsafe transfer.

In an interview with PSW #132 and as per the home's investigation notes, they reported that they did not notify RPN #134 when the resident was on the floor. Instead, a mechanical lift was used to transfer the resident up off the floor and the registered staff was later notified about the fall.

In an interview with DOC #101, they acknowledged that as per the home's policy, the PSWs should have notified the registered staff that the resident was on the floor and the registered staff should have assessed the resident prior to them being lifted off the floor.

The home did not ensure that PSWs #132 and #133 immediately notified RPN #134 of resident #025's fall, therefore a head to toe assessment of the resident was not completed prior to them being moved, as per their "Falls Prevention Management Program" policy. [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.

Issued on this 28th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), DIANNE BARSEVICH (581), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2020_661683_0008
Log No. / No de registre :	021447-19, 021448-19, 023434-19, 023435-19, 001701-20, 001913-20, 003012-20, 003349-20, 003350-20, 003378-20, 003848-20, 004689-20, 008052-20, 008718-20, 009448-20, 010272-20, 010560-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 24, 2020
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
	Mieke Ewen

Ontario

Ministry of Long-Term Care

Ministère 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

Name of Administrator /
Nom de l’administratrice
ou de l’administrateur :

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_661683_0020, CO #002;

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.

The licensee shall prepare, submit and implement a plan to ensure:
1. All residents receive the correct diet texture as per their plan of care.
2. All residents receive Cardio-Pulmonary Resuscitation (CPR) when required and as per their plan of care.
3. Resident #021, and any other resident's safety plan is followed as per their plan of care.

The plan must include but is not limited to:
i) The training of PSW #106 on resident diet textures and where to locate resident diet information;
ii) Training of RPN #105 on the home's "Code Blue" policy;
iii) When the training will be completed and how the training will be documented and;
iv) A process outlining safety interventions and staff breaks.

Please submit the written plan for achieving compliance for inspection #2020_661683_0008 to Lisa Bos, LTC Homes Inspector, MLTC, by email to hamiltonsao.moh@ontario.ca by August 14, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO)

#002 from inspection #2019_661683_0020 issued on November 22, 2019, with a compliance due date of April 20, 2020.

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.

The licensee completed steps 1 and 2 in CO #002.
The licensee failed to comply with s. 6. (7).

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #002 and #021 as specified in the plan.

A) A Critical Incident (CI) report was submitted to the Director under the category of unexpected death for resident #002.

A review of the resident's clinical record, the CI report and the home's investigation notes identified that PSW #106 gave resident #002 something to eat and shortly after, the resident had a change in condition, so they notified Registered Practical Nurse (RPN) #105.

In an interview with RPN #105 and according to their written statement, they indicated that at an identified time, they walked past the resident and they appeared well. They assessed the resident and then performed an intervention. They indicated that a pulse was absent and they called Registered Nurse (RN) #104.

A review of documentation by RN #104 indicated that when they arrived on scene, the resident's death was pronounced. They documented that the resident was a full code, but noted that when they arrived on the unit, the resident already passed and Cardio-Pulmonary Resuscitation (CPR) would have been no benefit.

i. A review of the resident's written plan of care in place at the time of the incident indicated that they required a specific food and fluid consistency related to an identified diagnosis and there were various interventions in place related to eating.

In an interview with PSW #106 they indicated that they were aware of the appropriate fluid consistency for the resident, and as per the home's investigation notes, they were unaware of the appropriate food consistency for the resident.

In an interview with DOC #102, they acknowledged that the food item provided to resident #002 was not appropriate, as per their plan of care.

The home did not ensure that resident #002 was provided with the appropriate diet texture, as per their plan of care.

ii. Resident #002's advance care planning document was reviewed, and it identified that they wished for CPR for witnessed arrest.

A review of the licensee's policy titled "Code Blue," last updated April 15, 2020, identified that the purpose of a Code Blue for CPR was to achieve the prompt restoration of effective circulation and respiration in residents suffering a cardiac event. Where appropriate or based on the advanced plan of care of an individual resident, certified staff were to initiate CPR until emergency/ambulance personnel arrived. The policy indicated that CPR was initiated at St. Joseph's Villa for an actual witnessed cardiac arrest in the absence of a Do Not Resuscitate (DNR) order, or in the absence of an expressed wish not to be resuscitated.
The guideline identified the following:

-The arrest should have been witnessed by a reliable observer, or where able to determine that the arrest has occurred within minutes of when the resident was last seen functioning normally (Health Professionals must use clinical judgement to determine whether to proceed with CPR taking into account signs such as: absence of vital signs, skin discolouration, lividity, fixed stare, corneal opacfication, rigor mortis).

-The event should have been unexpected, given the clinical situation.

-The resident should not be suffering from a complex multi-system medical problem that has been shown not to benefit from CPR. This would have been determined by the team as part of the treatment plan.

-The resident clearly does not have an illness for which death would be the expected outcome.

The home did not ensure that CPR was provided to resident #002 as per their wishes specified in their plan of care.

B) According to CI #2976-000017-20, on an identified date, there was an altercation between resident #021 and resident #022.

Resident #021's plan of care directed staff to refer to the resident's safety plan in place, which outlined the use of a specific intervention due to an increase in responsive behaviours.

A progress note indicated that resident #022 was negatively effected by resident #021. The unit staff were informed of this and interventions were put into place. Another progress note from the same date indicated that resident #021 was demonstrating behaviours towards resident #022, causing resident #022 harm.

In an interview with staff #118, PSW #112 and PSW #121, they stated the safety intervention was not in place as required in the plan of care.

Resident #021's plan of care was not followed in regard to their safety plan, resulting in an altercation toward resident #022 causing harm (586).

The severity of this issue was a level 3 as there was actual risk to the residents. The scope was a level 1 as it related to three of nine residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of the LTCHA and four or more compliance orders that included:

• Compliance Order (CO) #002 issued October 26, 2017, with a compliance due date of December 8, 2017 (2017_542511_0011);
• CO #001 issued July 3, 2019, with a compliance due date of October 31, 2019 (2019_549107_0007);
• Written Notification (WN) issued August 20, 2019 (2019_555506_0005);
• Voluntary Plan of Correction (VPC) issued October 25, 2019 (2019_560632_0020);
• CO #002 issued November 22, 2019, with a compliance due date of April 20, 2020 (2019_661683_0020);
• WN issued February 21, 2020 (2020_661683_0001).

Additionally, the LTCH has a history of 21 compliance orders to other subsections in the last 36 months. (683)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_560632_0020, CO #001;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:

1. Ensure that staff use safe transferring devices or techniques when assisting resident #003 and all other residents.

2. Retrain PSW #132, PSW #133 and all direct care staff on an identified home area on the home's "Resident Handling - Lifts, Transfers and Repositioning" policy. The training is to include, but is not limited to, how to transfer a resident off the floor after a fall. The home is to maintain documentation of which staff received the training and when they received it.

3. Retrain PSWs #132 and #133 on how to access resident transfer status electronically in Point Click Care. The home is to maintain documentation of when these staff received the training.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2019_560632_0020 (A2) issued on December 19, 2019, with a compliance due date of April 20, 2020.

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must:

1. Ensure staff working in Oak Grove home area use safe transferring techniques, when assisting residents #012, #014 and #067 and all other residents.
2. Ensure all direct care staff working in Oak Grove home area receive retraining regarding safe transferring techniques when assisting residents #012, #013 and #067 and all other residents.
3. Establish an auditing process to ensure that staff working in Oak Grove home area, using transferring devices or techniques to assist residents #012, #013 and #067, are using safe techniques appropriate to the needs of the resident.
4. Ensure documentation be retained of staff retraining and staff audit results.

The licensee completed steps 2, 3 and 4 in CO #002.
The licensee failed to complete step 1.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents #003 and #025.

A) The home's policy number POL-05 titled "Resident Handling - Lifts, Transfers and Repositioning," last revised November 26, 2019, identified that it was the responsibility of the employer to ensure that all staff complied with the philosophy of a minimal lift facility. The policy identified that staff were to adhere to the designated lift/transfer status as identified on each resident's care plan and for the safety of both the resident and staff, only the designated transfer method was to be used.

i. Review of the clinical health record identified that resident #003 had a fall on an identified date and was manually lifted off the floor.

Review of a note documented by the Physiotherapist indicated that the resident was reassessed, and they required a mechanical lift for transfers.

Following a review of the plan of care and interview with DOC #102, they confirmed the home had a minimal lift policy in place and residents that had been assessed as a mechanical lift for transfers were to be transferred from the floor with a mechanical lift.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

ii. Review of the clinical health record indicated that resident #003 fell on an identified date, and they were manually lifted off the floor.

A review of a note documented by the Physiotherapist indicated that the resident was to be transferred with a mechanical lift for all transfers.

During an interview with the DOC #102, they confirmed the resident was transferred off the floor with a manual transfer by staff and stated a mechanical lift should have been used.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

iii. On an identified date, resident #003 sustained a fall and was transferred off the floor with a manual lift.

Review of a note documented by the Physiotherapist indicated that the resident was reassessed, and they required a mechanical lift for transfers.

Following an interview and review of the plan of care with DOC #102, they acknowledged that the resident was to be transferred with a mechanical lift for all transfers and should not have been transferred off the floor manually by staff.

DOC #102 confirmed resident #003 was transferred off the floor post fall with an unsafe transfer.

The licensee failed to ensure staff used safe transferring techniques when resident #003 was manually lifted off the floor post three falls.

B) A complaint was submitted to the Director regarding the improper care of resident #025.

Resident #025 resided at St. Joseph's Villa for an identified period of time. A review of their written plan of care in place at the time of the incident identified

that they required a mechanical lift for transfers and they were non-weight bearing. The home received a call regarding the complaint about the care of the resident and the home initiated an internal investigation. Seven days later, ADOC #123 was contacted and notified of a significant change in the resident's status. As per the home's amended CIS report, their internal investigation revealed that the resident had a fall that was not documented.

A review of the home's internal investigation notes indicated that on an identified date, PSW #132 went to transfer resident #025, but they could not locate any documentation of their transfer status and they did not receive assistance from RPN #134 in finding the information. They indicated that they transferred the resident with the assistance of PSW #133 using a non mechanical type of transfer. They indicated that instead of immediately notifying the registered staff, they used a mechanical lift to get the resident up off the floor and later reported the fall to registered staff.

In an interview with DOC #101, they acknowledged that PSW #132 and #133 did not use safe transferring techniques for resident #025, which resulted in a fall.

The severity of this issue was a level 3 as there was actual risk to the residents. The scope was a level 2 as it related to two of four residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of the LTCHA and four or more compliance orders that included:

• Voluntary Plan of Correction (VPC) issued August 20, 2019 (2019_555506_0005);
• Compliance order (CO) #001 issued December 19, 2019, with a compliance due date of April 20, 2020 (2019_560632_0020 (A2)).

Additionally, the LTCH has a history of 23 compliance orders to other subsections in the last 36 months. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2020

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. Falls prevention and management

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 49. (2).

Specifically, the licensee must:

1. Ensure that when resident #003 and all other residents fall, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
2. Retrain PSW #132 and PSW #133 on the home's "Falls Prevention Management Program" policy. The training shall include, but is not limited to, identifying a fall and immediately reporting the fall to registered staff.
3. Retrain RPN #107, RPN #134 and RPN #155 on when to complete a post fall assessment and where the assessment is to be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that when residents #003, #004 and #025 fell a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's policy number POL-03, titled "Falls Prevention Management Program," last revised December 24, 2019, defined a fall as "an event that results in a person coming to rest inadvertently on the ground or floor or other lower level."

The policy indicated that a fall was considered:
-when a resident lost his/her balance and would have fallen if staff did not intervene;
-if the fall resulted in injury;
-if a resident was found on the floor, and staff could not definitively rule out a fall,

it was to be considered a fall;
-the distance to the next lower surface is not a factor. If a resident rolls onto the floor from a mattress placed on the floor, it is still a fall.

A) Review of the clinical health record identified in a progress note documented by RPN #155 that on an identified date, resident #003 sustained a fall.

Review of the plan of care identified that a post fall assessment was not completed.

Following an interview and review of the plan of care with DOC #102 they stated that any change in surface level was a fall and a post fall assessment should have been completed by registered staff.

DOC #102 confirmed that a post fall assessment was not completed using a clinically appropriate assessment instrument by registered staff when the resident was found on the floor.

B) A review of a progress note documented in resident #004's clinical health record indicated that on an identified date, they sustained a fall. RPN #107 assessed the resident and completed a post fall assessment. RPN #107 then documented later that they went to locate the resident and found them on the floor again.

Review of the clinical record identified that a post fall assessment was not completed after the second fall.

Following an interview and review of the plan of care with DOC #102, they acknowledged that a post fall assessment was not completed using the licensee's post fall assessment tool and confirmed that it was their expectation that staff completed a Fall Incident electronic document when residents fall.

C) A complaint was submitted to the Director regarding the improper care of resident #025.

A review of the home's internal investigation notes indicated that on an identified date, resident #025 had an undocumented fall when PSWs #132 and #133

completed an unsafe transfer.

A review of the resident's clinical record did not identify a post fall assessment for their fall.

In an interview with PSW #132 and as per the home's investigation notes, they reported that they did not notify RPN #134 when the resident was on the floor. Instead, the resident was transferred up off the floor and the registered staff was later notified about the fall.

In an interview with RPN #134 and as per the home's investigation notes, they indicated that they did not recall PSW #132 reporting a fall for resident #025 to them, therefore they did not assess the resident.

The home did not ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (683)

The severity of this issue was a level 2 as there was minimal risk to the residents. The scope was a level 3 as it related to three of four residents reviewed. The home had a level 3 compliance history as they had previous non-compliance to the same subsection that included:
• Voluntary Plan of Correction (VPC) issued July 13, 2018 (2018_689586_0014)

Additionally, the LTCH has a history of 24 compliance orders to other subsections in the last 36 months. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 004

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

Linked to Existing Order / Lien vers ordre existant: 2020_661683_0001, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of O. Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure that resident #012, and all other residents, are administered drugs in accordance with the directions for use specified by the prescriber.

The plan must include but is not limited to, a detailed analysis of recurring medication errors and additional steps the licensee is taking to promote safe medication administration.

Please submit the written plan for achieving compliance for inspection #2020_661683_0008 to Lisa Bos, LTC Homes Inspector, MLTC, by email to hamiltonsao.moh@ontario.ca by August 14, 2020.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2020_661683_0001 issued on February 21, 2020, with a compliance due date of March 31, 2020.

The licensee must be compliant with O. Reg. 79/10, s. 131. (2).

Specifically, the licensee must:
1. Ensure that residents #002, #013, #014 and all other residents are

administered drugs in accordance with the directions for use specified by the prescriber.

The licensee failed to complete step 1 regarding medication being administered to residents in accordance with the direction for use.

The licensee has failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

A review of resident #012's clinical record identified they had an order for a medication three times daily. On an identified date, documentation indicated that resident #012 received an extra dose of the medication. The medication incident binder was reviewed, and a medication incident report was submitted for the identified date, indicating that resident #012 received an extra dose of the medication as well as their regular scheduled dose. Documentation confirmed that the physician was contacted, and heightened monitoring was ordered to ensure there was no harm to the resident. Interview with RPN #116 confirmed that the resident requested to have an extra dose of the medication. The RPN confirmed that the resident did not receive the correct dose of the medication.

A review of resident #012's clinical record indicated on an identified date, they did not receive a dose of a medication, but it was documented as given. The medication incident binder was reviewed, and a medication incident report was submitted, indicating that resident #012 did not receive their medication as ordered. Documentation indicated that the resident required extra monitoring but did not result in any harm to the resident. Interview with RPN #115 confirmed that they did not dispense the medication from the correct location and confirmed that the resident did not receive their medication as prescribed.

An interview with DOC #101 confirmed that on these two dates the resident did not receive their medication in accordance with the directions for use specified by the prescriber.

The severity of this issue was a level 2 as there was minimal harm to the residents. The scope was level 1 as it related to one out of 3 residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of O. Reg. 79/10 and four or more compliance

orders that included:
-Voluntary Plan of Correction (VPC) issued October 26, 2017 (2017_542511_0011);
-VPC issued November 10, 2017 (2017_569508_0013);
-VPC issued July 13, 2018 (2018_659586_0014);
-Compliance order (CO) #007 served on November 6, 2019 (2019_560632_0020).
-Compliance order (CO) #001 served on February 21, 2020 (2020_661683_0001).

Additionally, the LTCH has a history of 24 compliance orders to other subsections in the last 36 months. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 005

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

Linked to Existing Order / Lien vers ordre existant: 2019_661683_0020, CO #001;

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 shall:
1. Ensure that all residents are protected from neglect by staff.
2. Ensure that resident #029 and any other resident are protected from abuse by staff.
3. Retrain staff #139 on the home's policy to promote zero tolerance of abuse and neglect of residents. A record of the training shall be documented and kept in the employee's file.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2019_661683_0020 issued on November 22, 2019, with a compliance due date of February 28, 2020.

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.

The licensee completed steps 1 and 2 in CO #001.
The licensee failed to comply with s. 19 (1).

The licensee has failed to ensure that resident #029 was protected from abuse.

According to CI report #2975-000023-20, while Personal Support Worker (PSW) #139 was providing care to resident #029, it resulted in harm to the resident.

This information was confirmed through record review of the home's internal investigation notes and the resident's health record, as well as interviews with DOC #102 and PSW #139. DOC #102 confirmed that this met the definition of abuse.

Resident #029 was not protected from abuse by PSW #139 resulting in harm. [s. 19. (1)]

2. The licensee has failed to ensure that resident #025 was not neglected by the licensee or staff.

O. Reg. 79/10, s. 5. defines neglect as "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."

A complaint was submitted to the Director regarding the improper care of resident #025.

i. Review of the clinical health record for resident #025 identified that they resided at St. Joseph's Villa for a period of time. On an identified date, ADOC #125 was notified of a concern regarding the care of the resident. An investigation was initiated.

ii. On an identified date, ADOC #123 was contacted about a significant change in the resident's status. A CI report was initiated by the home, the police were notified, and the home continued their investigation.

iii. A review of the home's internal investigation notes substantiated that the resident had an undocumented fall, as a result of an unsafe transfer. Specifically, the investigation notes indicated that on an identified date, PSW #132 went to transfer resident #025, but they could not locate any

documentation of their transfer status and they did not receive assistance from RPN #134 in finding the information. With PSW #133, an unsafe transfer was used to move the resident, resulting in a fall. They indicated that instead of immediately notifying the registered staff, they used a mechanical lift to get the resident up off the floor and later reported the fall to registered staff.

iv. A review of the clinical record for resident #025 identified that at the time of the incident, they required a mechanical lift for all transfers. There was no post fall assessment identified for this fall.

v. In an interview with RPN #134, they confirmed that they did not disclose the transfer status or assist the PSW staff in finding the transfer status of the resident. They indicated that a post fall assessment was not completed.

The home demonstrated a pattern of inaction which jeopardized the health, safety and well-being of resident #025 when RPN #134 failed to assist PSW #132 in locating the resident's transfer status, when the PSWs completed an unsafe transfer which resulted in a fall for the resident, when the PSWs failed to immediately notify the registered staff of the fall and transferred them up off the floor without being assessed, and when a post fall assessment was not completed.

The severity of this issue was determined to be a level 2 as there was minimal harm to the resident. The scope of the issue was a level 1 as it was related to one of five residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of legislation and four or more compliance orders that included:
-Compliance Order (CO) #001 issued March 3, 2017, with a compliance due date of May 30, 2017 (2017_57610a_0002)
-Written notification (WN) issued October 26, 2017 (2017_542511_0011);
-CO #002 issued October 11, 2017, with a compliance due date of January 11, 2018 (2017_690130_0001);
-CO #001 issued July 13, 2018, with a compliance due date of August 7, 2018 (2018_689586_0014);
-Voluntary plan of correction (VPC) issued August 20, 2019 (2019_555506_0005); and,
-CO #001 issued November 22, 2019 (2019_661683_0020).

Additionally, the LTCH has a history of 21 compliance orders to other subsections in the last 36 months. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 18, 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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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 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 24th day of July, 2020

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