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_0009	002792-20, 003570-20, 005374-20, 012456-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint 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 Critical Incident inspection #2020_661683_0008 and Director Order Follow Up inspection #2020_661683_0010.

The following intakes were completed during this complaint inspection:
Log #002792-20 was related to the prevention of abuse and neglect
Log #003570-20 was related to the prevention of abuse and neglect
Log #005374-20 was related to falls prevention and management and the prevention of abuse and neglect
Log #012456-20 was related to falls prevention and management and the prevention of abuse and neglect

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) were identified in this inspection and have been issued in inspection report #2020_661683_0008, which was conducted concurrently with this inspection.

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
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident that could not be investigated and resolved within 10 business days, a follow-up response indicating what the licensee did to resolve the complaint or that the licensee believed the complaint to be unfounded and the reasons for the belief, was provided as soon as possible in the circumstances.

A review of the home's policy POL-05 titled "Complaints," last revised January 8, 2018, identified that when family members speak to staff about concerns regarding resident care, treatment or safety, the manager/supervisor would investigate the concerns, and consider the following strategies to resolve the complaint depending on the nature of the circumstances: Confirm that the issue has been resolved to the complainant's satisfaction. Even if the complaint can't be resolved, acknowledgement by the complainant that they understand that it can't be resolved must be documented.

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

A review of the clinical record for resident #025 indicated that the long-term care home (LTCH) was notified of their Power of Attorney's (POA) concerns about the care of the resident. Assistant Director of Care (ADOC) #125 contacted the resident's POA and indicated that an investigation would be initiated and requested some information. Upon

receiving the information, ADOC #123 and Nurse Practitioner (NP) #131 discussed recommendations with the POA. Several days later, the resident's POA contacted ADOC #123 and discussed a new diagnosis. As a result, a CI report was initiated by the home, the police were notified, and the home continued their investigation.

Upon discussion with the resident's POA, they identified that they did not receive a response from the LTCH with regards to the outcome of the investigation.

A review of the complaint form in the electronic record for resident #025 identified that the resident's POA was contacted on an identified date and a voicemail was left. There was no further documentation that the home attempted to contact the complainant again with the outcome of their investigation.

In an interview with Director of Care (DOC) #101, they indicated that they had an initial conversation with the resident's POA and they attempted to contact them partway through their investigation but they were unable to reach them. They acknowledged that there was no final update provided to the resident's POA.

The home did not ensure that upon completing their investigation into a complaint regarding the care of resident #025, that a response was provided to the complainant that indicated what the licensee did to resolve the complaint and the outcome of their investigation. [s. 101. (1) 2.]

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.