Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
Dec 6-9 and Dec 14,15,17, 2010	2010-173-2975-06Dec092724 2010-173-2975-06Dec101040	Complaint Log # H02601,H02627, H02934 CIS Review Log # H02589, H02551, H02486,H02772

Licensee/Titulaire
St. Joseph's Health System
56 Governors Road, Dundas, Ontario L9H 5G7

Long-Term Care Home/Foyer de soins de longue durée
St. Joseph's Villa
56 Governors Road,
Dundas , Ontario L9H 5G7

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – Compliance Inspector – Nursing #173

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct three complaint inspections, and three critical incident inspections.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Nurse Unit Managers, Registered Staff, Personal Support Workers, Physiotherapist, Family members, residents, and Administrative support staff.

During the course of the inspection, the inspector: Reviewed policy and procedures, observed resident care, observed medication administration, reviewed resident clinical health records,

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Continence Care Inspection Protocol
Responsive Behaviours Inspection Protocol
Skin and Wound Care Inspection Protocol
Falls Prevention Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

5 WN
5 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O.,2007 c8, s.6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear direction to staff and others who provide direct care to the resident.

Findings:

1. The plan of care for three identified residents did not provide clear direction to staff in relation to toileting needs.
2. The plan of care for an identified resident did not provide clear direction to staff in relation to falls prevention and management.
3. The plan of care for an identified resident did not provide clear direction to staff in relation to responsive behaviours.

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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 related to developing a process to ensure clear direction is provided to all staff and others who provide direct care of the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O.,2007 c8, 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

Findings:

1. An identified resident's plan of care indicates that the resident is to be toileted before and after meals and before bed. Care for this resident was monitored for a period of 3.5 hours. The resident was not toileted prior to lunch meal, or after lunch meal by staff. During interview, the resident indicated that the resident requires assistance from staff to go to the toilet.

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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 related to developing a process to ensure that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10 s.8(1)(b)
Where the Act or this Regulation required 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 shall ensure that the plan, policy, protocol. Procedure, strategy or system
(b) is complied with

Findings:

1. **Resident Abuse Policy - Risk Management RSK - POL/9 was not followed in relation to the abuse investigation for two identified residents.**

- **Section 4.8.1 of this policy states: Communication is essential regarding incidents or potential incidents of abuse therefore any concern or evidence regarding abuse, witnessed or suspected must be reported immediately to the department manager, supervisor or delegate. Failure to report will be considered as further abuse and persons are subject to discipline up to and including termination.**
- A family member reported bruising on an identified resident to the home. The resident was able to explain that an incident had occurred. The staff had documented the incident in the residents chart, but did not initiate an investigation into the events until the family came forward. The family who reported the injury was not the Power of Attorney for this resident. The home did not report the incident to the Power of Attorney for 12 days.
- During interview with the unit manager who conducted the internal investigation, the resident's family member also indicated that there were other concerns,but this was not further investigated by the team when reported.

- **Section 4.8.2. of this policy states: When there is suspected injury due to physical abuse, the attending physician will be notified. Further the unit manager/delegate will inform the next of kin/power of attorney/PGT.**
- A family member reported bruising on an identified resident to the home. The resident was able to explain that an incident had occurred. The staff had documented the incident in the residents chart, but did not initiate an investigation into the events until the family came forward. The family who reported the injury was not the Power of Attorney for this resident. The home did not report the incident to the Power of Attorney for 12 days.

- **Section 4.10.2. of this policy states: The manager/supervisor investigating the incident documents a detailed report describing the situation and including:**
  - **Interview with the resident involved as soon as possible noting all responses accurately.**
  - **Possible reasons for the incident (as the person preparing the report sees it).**
  - **If obtainable, written signed statements from witnesses**
  - **Interviews with all staff who worked on the shift involved.**
  - **Actions taken at all phases of the investigation**
- During an internal investigation into allegations of abuse, an identified resident was not interviewed as per policy. This resident is fully capable of giving an statement.
- During investigation into alleged abuse of an identified resident, no written statements were taken by any staff members, including the accused staff member.
- During investigation into alleged abuse of an identified resident, no report or documentation was noted that described actions taken at all phases of the investigation.

- **Section 4.12.2 of this policy states: Action is dependent upon the severity of the incident, the effect on the resident, the employees work record and length of service and his/her remorse or lack of it. Non-disciplinary action may include:**
  - **Counseling/EAP**
  - **Supervised job reviews**
  - **reassignment of duties/work areas**
  - **review and reinstruction of staff to reinforce Villa Standard, policies and/or care planning**
  - **Performance discussions with specific objectives outlined with a written follow up summary.**
- Notes of investigation provided indicate that the staff member was not disciplined, but gives no further details.

- **Section 4.13.2.of this policy states: That resident and/or family member have been adequately informed and have direct communication where so indicated.**
- At the conclusion of the investigation of alleged abuse of an identified resident, the home did not provide the outcome of the investigation to the resident, only to the resident's Power of Attorney. During interview with this resident, the resident indicated that the resident was aware of the investigation and was not approached in any way by staff to get a statement of events or let the resident know the outcome of the investigation.

2. **Administration Policy ADM-POL/5 was not followed in relation to procedure for reporting complaints to the Ministry of Health**

- **Section 4.5 of this policy states: A copy of all written complaints received will be forwarded to the MOHLTC. Documentation of the follow up action taken will be included.**
- Documentation forwarded to the Ministry of Health and Long Term Care related to a complaint received for an identified resident did not include documentation of follow up actions taken in relation

to this complaint received by the home. During interview with the Director of Care's Administrative support staff, it was indicated that the response to the complaint would have been forwarded by the unit manager. When asked if home had fax confirmation that this occurred, the staff person indicated that fax confirmations were not used by the home and that she did not know of any formal process to track if documents have been forwarded as required.

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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 related to ensuring that all policies and procedures required by the home are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10 s. 50(2)(b)(ii)
Every licensee of the long-term care home shall ensure that,
a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Findings:

1. During review of clinical record of an identified resident, staff document several times on the weekly skin assessment that the resident's wound appeared to be worsening. There is no evidence that action was taken as a result of this assessment.
2. An identified resident was diagnosed and treated for an infection that was not identified by the staff in the home.
3. An identified resident was diagnosed and treated for an infection that was not identified by staff in the home.

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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 related to ensuring that all resident exhibiting skin breakdown, ulcers, tears or wounds receive immediate treatment and interventions to relieve pain, promote healing and prevent infection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA 2007, S.O. 2007 c.8, s6(5)
The licensee shall ensure that the resident, the residents substitute decisions make, if any, and any other person designated by the resident or substitute decision maker are given an opportunity to participate full in the development and implementation of the residents plan of care.

Findings:

1. An identified resident had open areas that required treatment and ongoing testing procedures to rule out circulatory and infection concerns. Plans related to treatment of these areas and tests ordered were not sufficiently communicated to the resident and family members by the home. Documentation reviewed indicated that tests requested by the physician were delayed for several reasons that were not communicated to the resident or Power of Attorney. The Physician was away from the home on vacation without communicating the change in plans and delay of testing to the resident and POA.

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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 related to developing a process to ensure that all residents are able to participate in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). July 19/11