Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 14, 2023
Original Report Issue Date: June 28, 2023
Inspection Number: 2023-1458-0003 (A1)
Inspection Type: Critical Incident System
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Villa, Dundas,Dundas

Amended By	**Inspector who Amended Digital Signature**
Olive Nenzeko (C205)	Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2023.07.17 11:40:06 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This public inspection report has been revised to reflect the change made to the CDD from August 04, 2023, to September 05, 2023, and to add the Compliance Order (CO) number #001, statement to the ground of the CO and to modify impact/risk statement for the CO.

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Lead Inspector Olive Nenzeko (C205)	**Additional Inspector(s)** Michelle Warrener (107)
Amended By Olive Nenzeko (C205)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-12, 15-17, 19, 23-26, 29-31, 2023 and June 1, 2023

The following intake(s) were inspected:

- Intake: #00001626- CI: 2975-000033-21 related to Prevention of Abuse and Neglect
- Intake: #00002929 - CI: 2975-000021-21 related to Medication Management

· Intake: #00011139 - CI: 2975-000047-22 related to Falls Prevention and Management
· Intake: #00085531 - CI: 2975-000022-23 related to Falls Prevention and Management
· Intake: #00012249 -2975-000051-22 related to Falls Prevention and Management

The following intakes were completed in this inspection:

· Intake# 00001246/CI# 2975-000004-22, Intake# 00001740/CI# 2975-000028-22, Intake# 00002149/CI# 2975-000022-21, Intake# 00002192/CI# 2975-000035-22/CI: 2975-000036-22, Intake# 00002326/CI# 2975-000009-22, Intake# 00002897/CI# 2975-000030-22, Intake# 00003140/CI# 2975-000032-21, Intake# 00003687/CI# 2975-000026-21 , Intake# 00004700/CI# 2975-000031-22, Intake# 00005500/CI# 2975-000034-22, Intake# 00010785/CI# 2975-000045-22, Intake# 00012238/CI# 2975-000050-22, Intake # 00012818/CI# 2975-000054-22, Intake# 00013895/CI# 2975-000059-22, Intake# 00013922/CI# 2975-000060-22, Intake# 00014133/CI# 2975-000062-22, Intake# 00015786/CI# 2975-000070-22, Intake# 00016099/CI# 2975-000071-22, Intake# 00017394/CI# 2975-000003-23, Intake# 00021648/CI# 2975-000012-23, Intake# 00022390/CI# 2975-000015-23, Intake# 00084117/ CI# 2975-000018-23 and Intake# 00004128/CI# 2975-000023-22 were related to falls.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 52 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident was receiving routine pain medications daily and their plan of care included as needed (prn) pain medication for breakthrough pain. Staff identified that the resident was unable to consistently verbalize pain due to a condition and staff were to use a specific assessment tool for monitoring the resident's pain.

A pain assessment for the resident using a specific pain assessment tool, was required when the resident and/or their SDM identified or expressed pain verbally, non-verbally or through physical expression of pain, and also when pain was identified during a skin and wound assessment.

Between specific days in two months, there were five skin and wound assessments that identified pain and a corresponding pain assessment tool was not completed to measure and quantify the pain.

The resident had a responsive incident and the resident's pain was assessed at an increased level using a specific pain assessment tool. The resident's pain was not re-assessed using the specific pain assessment tool until three days later. Staff stated that the resident's pain should have been re-assessed over the next 24 hours to ensure the pain was managed.

The resident's plan of care included as needed medication for breakthrough pain, however, the resident did not receive this medication for two months.

The resident's pain was not consistently assessed or re-assessed using the specific pain assessment tool when the resident expressed pain outside of the weekly pain assessments. Staff could not accurately measure the frequency, severity, or patterns/causes of pain outside of the weekly pain assessments.

Sources: Interview with staff, resident's eMAR , Skin and Wound Assessments, Pain

assessments tool and pain scores, home's policies.[107]

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

The licensee has failed to ensure that where the LTCHA, 2007 or O. Reg 79/10, required the licensee of a long-term care home put into place any policy that the policy was complied with.

In accordance with LTCHA, 2007 s. 8 the licensee was to ensure that there was an organized program of nursing services to meet the assessed needs of residents.
Specifically, staff did not comply with the home's policy for monitoring and managing a medical condition's symptom and for administering a specific medication.

Rationale and Summary
A) The home's policy directed staff to closely monitor and re-assess the resident within an identified time following administration of a specific medication.

Clinical records identified that a resident had the specified medical condition's symptom that required treatment with a medication and resident to be re-assessed within a specific time. A staff recorded that the medication was administered as soon as they could be found. Resident was re-assessed an hour late.

Staff confirmed that they did not follow the home's policy and that the resident was re-assessed and hour late after administering the medication.

B) According to the home's Policy, a specific medication's kits were kept in the Medication Cart for all residents who had a Physician's order as well as Emergency Starter Boxes on specific residents' home areas.

A review of clinical records identified that staff could not find the medication easily to administer to the resident and that they found the medication kit from another resident on the same unit and used it. Staff confirmed that the medication was not available and that they had

to use another resident's medication.

Staff failure to comply with the home's policies put the resident at risk of a severe reaction not being identified on time and appropriate action not being taken.

Sources: Medication incident report, home's policies and interview with staff. [C205]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 30 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, reassessments, interventions, and the resident's responses to interventions, were documented.

Rationale and Summary:
A resident had multiple areas of skin impairment requiring weekly skin monitoring and treatments. Documentation was not consistently completed for the following areas on the resident's electronic treatment administration record (eTAR) for a month:
a) Treatments were not signed as completed over two weeks for a specific body part.
b) 16 missing shift signatures for topical medication.
c) 16 missing shift signatures for a specialized device.
d) The order for a wound was not documented on the eTAR.
e) Weekly wound assessments for specific days were missing staff signatures.

The Skin and Wound Lead confirmed that it was unclear from the documentation if the care was being provided to the resident and the documentation was incomplete or if care was not provided, however, noted that treatment records were required to be signed and completed by staff assigned to the task.

With documentation incomplete for multiple treatments, it was unclear if the care was provided to the resident.

Sources: Resident's eTAR and progress notes , weekly skin and wound assessments and Physician orders, interview with staff.[107]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (iv)

The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Rationale and Summary
For a specific period of time, a resident did not have a weekly re-assessment by a member of the registered nursing staff for the following areas of skin breakdown:

a) A skin assessment was completed for the resident's specific body part on an identified date. The assessment did not identify the area had healed/resolved and the area was not re-assessed using the home's weekly skin assessment form (UAT) between a specific period of time. The resident continued to have treatments provided to the body part until the treatment order was discontinued. A skin assessment was not completed when the treatment was discontinued to identify if the area had resolved or rationale for discontinuation of the treatment. A new assessment was initiated for the body part the next month with an increase in the skin impairment.

b) A weekly skin and wound assessment for significant altered skin integrity to the resident's specific body part was completed on an identified date, and the assessment did not indicate the area had resolved. No further weekly wound assessments were completed for the area. Staff identified that the altered skin integrity was still visible nineteen days later. Staff confirmed that the altered skin integrity was required to have weekly skin assessments until it was no longer visible.

c) A weekly skin assessment was completed for an incontinence condition on an identified date, and the skin impairment had not been resolved on the assessment. There was no further

assessment of the area until almost a month later, when a new assessment was initiated for the same area. Staff could not confirm if the area had healed with new impairment or if the area had deteriorated while weekly assessments were not being completed.

d) A skin assessment for a skin impairment was completed on three dates within one month, and the area had healed/resolved on the last assessment. There were 15 days between the first and second assessment.

e) Only one of the Scheduled Weekly wound assessments was signed as completed for the month

Without weekly wound assessments the resident was at risk of deterioration of the areas. It is not clear if some of the areas of skin impairment deteriorated while the areas were not being monitored.

Sources: Resident's UAT weekly skin and wound assessments and progress notes, eTAR , interview with staff, Skin and Wound Management policy POL-11, Skin & Wound Care Program.[107]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The Licensee has failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours.

Rationale and summary
A resident had a history of responsive behaviours and their plan of care included a specific intervention to ensure the resident's safety.

On an identified date, the resident had a fall resulting in an injury.

A review of the clinical records identified that the specific intervention for the resident was not

implemented.

RCM confirmed that the specific intervention was not implemented and that it should have been done.

Failure to implement strategies to manage the resident 's responsive behaviours could have prevented the fall of the resident.

Sources: Resident's clinical records, Interview with RCM and DOC. [C205]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4)

The licensee has failed to inform the Director of resident's fall with injury no later than three business days after the occurrence of the incident where the licensee determined that the injury resulted in a significant change in the resident's health condition.

Rationale and Summary:

A resident had a fall with a suspected injury on an identified date. The resident was taken to the hospital and returned later the same day. Notes from the hospital emergency department identified the resident sustained an injury from the fall.

The day after the resident returned from hospital, a Head Injury Routine assessment identified an injury with a change in activities of daily living, where the resident required more assistance. A progress note the same day identified the resident was in pain, was unable to walk with their assistive device and required a different assistive device. A Physiotherapy referral, initiated within three days after the resident's fall, identified an injury with change in resident's care needs. Staff confirmed that documentation in the resident's record reflected a significant change in the resident's condition after the fall, however, the Director was not notified until over a week later. Staff confirmed that information about the resident's condition after the fall was also not obtained from the hospital within three days.

Sources: Resident's clinical health records, After Hours report IL-06336-AH; Critical Incident report #2975-000047-22, interviews with staff. [107]

COMPLIANCE ORDER CO #001 Doors in a home

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Update the licensee's written policy related to balcony access to include the need for balconies to be supervised when the doors are left unlocked.
b) Educate PSW staff and Registered staff, on all shifts, of the revised policy related to balcony access.
c) Document the training provided to PSW and Registered staff, including the date the training was provided, and the names and designation of the staff who attended the training.
d) Complete audits on non-secured home areas daily on the night shift for a 3 week period to ensure that the policy has been implemented or until such time that the compliance is achieved.
e) Ensure that when doors to the balconies are unlocked, that the areas are supervised.

Grounds
The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were locked to restrict unsupervised access to those areas by residents.

Rationale and Summary:
Section 12 (1) 2 stated that all doors leading to balconies and terraces must be equipped with locks to restrict unsupervised access to those areas by residents. Therefore, doors to balconies must be locked, or they must be supervised. The licensee's written policy on balcony access

identified that balcony doors were not required to be locked at all times and would be locked between November 1 and May 1. The home's policy did not include the requirement for supervision when the doors were unlocked.

A resident accessed a resident home area's balcony some time after 0300 hours on an identified date. The resident subsequently fell and was discovered at 0400 hours. The resident was sent to hospital where they were diagnosed with injuries and a noted symptom. According to hospital records, the air temperature that night was five degrees Celsius.

Staff confirmed that the doors to the home area balconies remain open and unrestricted to residents between May 1 and November 1 and remain unlocked during the night shift with the exception of the secure home area balconies. The resident was not located on a secure home area and staff confirmed that the door to the balcony was not locked or restricted on the night the resident fell.

The resident’s plan of care, prior to the fall, identified several factors that would increase the resident's risk with unsupervised balcony access, including difficulties with wayfinding on the unit and required re-direction by staff due to multiple conditions, extensive staff assistance with dressing, and use of an assistive device.

Failing to ensure supervision of the balcony doors was provided when the doors were left unlocked, a resident accessed a resident home area's balcony resulting in a fall with injuries.

Sources: Resident’s plan of care, progress notes, interview with staff, Clinical Connect notes from the hospital, POL-07 Environmental Safeguards, last revised date July 29, 2022. [107]

This order must be complied with by September 05, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.