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

Original Public Report

Report Issue Date: August 17, 2023

Inspection Number: 2023-1458-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: St. Joseph's Health System

Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas

Lead Inspector	**Inspector Digital Signature**
Betty Jean Hendricken (740884)	Elizabeth J Hendricken Digitally signed by Elizabeth J Hendricken Date: 2023.09.12 12:27:46 -04'00'

Additional Inspector(s)
Karlee Zwierschke (740732)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2023, August 1 -3 and 8 -10, 2023

The following intake(s) were inspected:

- Intake: #00001360 – critical incident related to prevention of abuse and neglect.
- Intake: #00001724 – critical incident related to medication management.
- Intake: #00009066 – critical incident related to responsive behaviours.
- Intake: #00091579 - complaint related to prevention of abuse and neglect and medication administration.
- Intake: #00092187 – critical incident related to fall prevention and management.

The following intakes were completed this inspection:

- Intake: #00090766 – critical incident related to fall prevention and management.
- Intake: #00088823 – critical incident related to fall prevention and management.

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

Medication Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that resident #006 was protected from physical abuse by resident #004.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
On an identified date, resident #004 was injured in an altercation with resident #006 during. The Director of Care (DOC) acknowledged that this incident would be considered physical abuse.

Sources: Resident #004 and Resident #006's clinical records, interviews with staff and DOC.
[740732]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that the physical abuse of resident #006 by resident #004 was submitted to the Director immediately.

Rationale and Summary
Critical Incident (CI) #2975-000024-22 was reported two days after an incident occurred. The Resident Care Manager (RCM) confirmed that this incident should have been reported immediately.

Sources: CI #2975-000024-22, interview with RCM and DOC.
[740732]

COMPLIANCE ORDER CO #001 Medication Management System

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee must:
A: Educate all registered staff on the following:
1. Pharmacy's specific identified policy: Ordering and Receiving Medication.
2. The home's specific identified policy: Management of High Alert Medications and Independent Double Check.
3. The home's specific identified policy: Medication Administration Rounds.

B: Maintain a written record of all training including dates, who attended and who provided the training.

Grounds
The licensee failed to ensure that their medication management policies for accurate acquisition and administration of drugs were implemented.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the medication management program had in place a procedure for accurate processing of physician orders and accurate medication administration of drugs and must be complied with.

Specifically, staff did not comply with the Ordering Medications Policy requiring two separate checks of the physician's order by registered nursing staff. Further, staff did not comply with the management of High Alert Medications and Independent Double Check Policy requiring an Independent Double Check for special high alert medications by the registered staff prior to administering the medication.

On an identified date, a Physician's Order was written for a medication. A review of the resident's Digital Prescriber's Orders identified that only one check was completed. The home's policy for ordering medications required two separate checks by registered staff to confirm the medication order.

On an identified date, a registered staff member administered the medication to the resident. A review of the resident's medication administration record identified that an Independent Double Check was not

completed. As per the home's High Alert Medications and Independent Double Check Policy, the administration of the medication required the registered staff member to complete an independent double check that included verifying the correct dose and correct dose calculation.

The DOC verified that the order received one of two required checks that should have been completed prior to medication administration. They further acknowledged that the registered staff member did not complete the Independent Double Check for the administration of the medication as required.

The physician confirmed that the order they wrote for the medication was incorrect resulting in a dosing error.

Failure to follow the home's policy for Ordering Medications, specifically processing prescriber's orders and failure to follow the homes High Alert Medications and Independent Double Check Policy resulted in a dosing error being missed and led to a negative resident outcome.

Sources: Staff interviews, Physician interview, resident's clinical records, Policy for Ordering and Receiving Medication, St. Joseph's Villa Policy for Management of High Alert Medications and Independent Double Check.
[740884]

The licensee has failed to ensure that their medication management policies for the accurate administration of drugs were implemented.

Rationale and Summary
Specifically, staff did not comply with the Medication Administration Rounds Policy requiring residents swallow medications when they are administered.

On an identified date, a resident handed a cup full of medications that they had been collecting to a registered staff member. During a medication administration observation, a registered staff member was observed leaving medication unattended. The home's Medication Administration Rounds Policy stated that medications were to be administered according to the College of Nurses of Ontario Medication Standards and registered staff were to ensure residents swallowed medications when they were administered.

The registered staff member confirmed that they did not follow the medication administration rounds policy as required.

Leaving medications unattended put residents at risk of harm from ingesting medications that were not

prescribed for them.

Sources: Staff interviews, resident interview, resident's clinical records, St. Joseph's Villa Policy for Medication Administration Rounds.
[740884]

This order must be complied with by October 6, 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.