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: October 24, 2023

Inspection Number: 2023-1458-0005

Inspection Type:
Critical Incident
Follow up

Licensee: St. Joseph's Health System

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

Lead Inspector	**Inspector Digital Signature**
Olive Nenzeko (C205)	Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2023.11.03 07:59:12 -04'00'

Additional Inspector(s)
Jennifer Allen (706480)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26-29, 2023, and October 3-6, 11, 2023.

The following intake(s) were inspected:

- Intake: #00017263/CI #2975-000002-23 related to an unexpected death.
- Intake: #00017691/CI #2975-000004-23 related to resident care and support services.
- Intake: #00018141/CI #2975-000007-23 related to prevention of abuse and neglect.
- Intake: #00020648/CI #2975-000010-23 related to responsive behaviours.
- Intake: #00097103/CI #2975-000050-23 related to falls prevention and management.
- Intake: #00091184 Follow-up to compliance order #001 from Inspection #2023-1458-0003 regarding O. Reg. 246/22, s.12 (1) 2- doors in a Home.
- Intake: #00094824 Follow-up to high priority compliance order #001 from Inspection #2023-1458-0004 regarding O. Reg. 246/22 - s. 123 (3) (a) - Medication Management System.

The following intakes were completed in this inspection: Intake: #00095391/CI #2975-000037-23; Intake: #00096012/CI #2975-000040-23; Intake: #00096920/CI #2975-000046-23 and Intake: #00093734/CI #2975-000033-23 related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1458-0003 related to O. Reg. 246/22, s. 12 (1) 2. inspected by Olive Nenzeko (C205)

Order #001 from Inspection #2023-1458-0004 related to O. Reg. 246/22, s. 123 (3) (a) inspected by Jennifer Allen (706480)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Comply with Plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan was provided.

Rationale and Summary
The resident's plan of care stated they should be wearing a specialized device at all times. In the resident's room, there were directions posted above the resident's bed that were to be followed at all times for the resident's safety. The resident was observed sitting in the home's

common area without their specialized device on. A staff confirmed that the resident did not have their specialized device on when they should have.

Sources: Resident's heath records; Observation of resident; Interview with staff.
[706480]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Rationale and Summary
O. Reg. 246/22 s. 2 (1) (c) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On a specific date, two residents were in the common area when staff witnessed one of the residents attempting to assist the other resident in sitting down or arguing with them in a different language; the other resident got up and pushed the resident onto the ground causing an injury.

There were progress notes from two previous responsive incidents involving both residents, both of which resulted in no injuries.

A staff admitted to witnessing the incident and was aware of contributing causes for the resident's behaviours.

Resident Care Manager (RCM) acknowledged that staff should have separated both residents as soon as they saw the two residents approach each other.

Failure to protect resident from physical abuse by another resident resulted in an injury.

Sources : Residents' clinical records; Interview with staff.
[C205]

WRITTEN NOTIFICATION: Skin and Wound

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure a resident received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
On a specific date, a resident returned from the hospital following an injury. Upon return from the hospital, the resident's wound was not assessed using an instrument that was specifically designed for skin and wound assessment until four days later.

A staff stated that the home's process for skin and wound assessment included using the Skin and Wound application. They admitted seeing the wound upon return from hospital but could not locate the assessment.

The home's Skin and Wound Care Program stipulated if altered skin integrity was identified, within 24 hours of readmission a member of the register staff will complete a skin and wound evaluation.

RCM confirmed it was the expectation for a readmission skin assessment to include all skin alterations and to be completed within 24 hours of readmission and that the expectation was to use the Skin and Wound application to complete the assessment.

Failure to assess the wound using a clinically appropriate assessment instrument that was specifically designed for skin and wound may have increased the risk of inaccurate wound assessment.

Sources: Skin and Wound Care Program Policy, resident's clinical health records; interviews with staff
[706480]