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: December 19, 2023
Inspection Number: 2023-1458-0006
Inspection Type: Critical Incident
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas

Lead Inspector	**Inspector Digital Signature**
Terri Daly (115)	Terri Daly Digitally signed by Terri Daly Date: 2023.12.29 12:15:31 -05'00'

Additional Inspector(s)
Adriana Congi (000751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, 6 & 7, 2023.

The following intake(s) were inspected:

- Intake: #00095297 - CI #2975-000036-23 - Unexpected death of a resident.
- Intake: #00099771 - CI #2975-000061-23 - Fall of a resident with injury.
- Intake: #00100377 - CI #2975-000066-23 - Fracture of unknown etiology.

The following intake(s) were completed in this inspection:
Intake: #00100110 - CI #2975-000063-23 - Related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

The licensee shall ensure that the care set out in the plan of care for a resident is provided as specified in the plan.

Rationale and Summary
A review of a Critical Incident indicated that a resident experienced an incident with injury. The Registered Nurse (RN) who found the resident documented that a specific intervention was not in place at the time of the incident.

A review of the resident's care plan indicated the use of a specific intervention for safety.

An interview with a Registered Nurse (RN), they stated that they had discovered the resident post incident and that the intervention noted in the care plan was not in place for this resident.

During an interview with the Director of Care (DOC), they acknowledged that the resident should have had this specific intervention in place for safety and at the time of the incident they did not.

Not having the intervention in place per the resident's care plan put the resident at risk for injury.

Sources: Critical Incident, staff interviews, the home's investigative notes and the resident's clinical record.

[115]

WRITTEN NOTIFICATION: Procedures and interventions not implemented for responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm and who were harmed as a result of a resident's responsive behaviours.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director, related to an injury as a result of a resident's responsive behaviours. The resident was demonstrating responsive behaviours and hit a personal support worker (PSW) during their care resulting in injuries for which the resident was transferred to hospital.

A review of the resident's care plan indicated two staff assistance was required with whole bathing activity due to behaviours. It indicated that PSWs were required to document a summary of each episode of this behaviour. The nursing flow sheet did not have any

documentation under responsive behaviors for the date of the incident.

The Director of Care (DOC) and Resident Care Manager (RCM) acknowledged that the care plan was not followed and that the resident's care was completed using only one staff assistance. The RCM acknowledged that it is an expectation that PSWs document the presence of responsive behaviors using the nursing flow sheet.

Failure to implement the procedures and interventions developed resulted in the resident sustaining an injury.

Sources: Critical Incident, resident's clinical record, and staff interviews.

[000751]

WRITTEN NOTIFICATION: Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee failed to ensure that when they were required to make a report in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident that the report was immediately made.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director for an unexpected death in the home.

The report indicated that a resident experienced an incident sustaining injury. The following day after the incident the resident's condition worsened and they subsequently passed away. Based on this information the incident was reported to the local coroner's office by the Long-Term Care (LTC) home.

Several months later the coroner contacted the LTC home requesting the Critical Incident (CI) number, so that the coroner's report and the CI could be linked. The Director of Care (DOC), shared that they did not realize a CI needed to and had not been submitted and therefore submitted the CI late under the category of unexpected death.

Not immediately reporting an unexpected death to the Director placed the resident at minimal risk.

Sources: Critical Incident, and staff interviews.

[115]