Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), ASHA SEHGAL (159), BERNADETTE SUSNIK (120), CAROL POLCZ (156), DEBORA SAVILLE (192), LALEH NEWELL (147), SHARLEE MCNALLY (141), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2013_188168_0016
Log No. / Registre no:	H-000212-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 10, 2013
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHAWN GADSBY

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To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to residents in relation to: level of assistance with toileting and transfer status, continence status, falls prevention interventions, safety devices and nutritional care needs.
The plan is to be submitted by July 5, 2013, to lisa.vink@ontario.ca.

Grounds / Motifs :

1. Previously issue as a VPC in March 2011, WN in April 2011 and as a VPC in January 2013.

Not all plans of care set out clear directions to staff and others who provided direct care to the resident.

A) The plan of care for resident #1001 indicated that staff were to "minimize environmental barriers" and "orientate to furniture/objects in key areas". During interview regarding the resident's falls, it was identified that the wheelchair was to be kept out of the residents sight to prevent self transfer and that the position of the bed may have contributed to the falls. The resident sustained two unwitnessed falls, one of which resulted in injury. Staff suspected that the falls occurred as a result of the resident attempting to self transfer. The plan of care created November 2011, and in effect at the time of the falls, did not provide clear direction regarding fall prevention interventions.

B) Resident #4000 had a physician's order for a tilt wheelchair and no other safety devices. The plan identified the use of the tilt chair, however the Care Summary Sheet, in the flow sheet binder on April 29, 2013, included a hand written revision which indicated that the resident used a seat belt. The plan of care did not give clear directions to staff providing care regarding safety devices to be used.
C) The plan of care for resident #9925, identified the requirement for total assistance with toileting and incontinence of bowel and bladder. The plan did not indicate that the resident was known to toilet independently however was unable to report bowel functioning. Interview with staff, progress notes and the Bladder Function and Bowel Movement Chart identified knowledge of this behaviour and for this reason the bowel protocol was not consistently followed. The plan of care did not provide clear direction for staff regarding the residents toileting/continence status.
D) The Active Care Plan Report for resident #4007 identified interventions under risk of falls and transferring as one staff to transfer, however the plan related to therapy falls and balance noted two staff to assist with transfers. The Health Care Record Display indicated that the resident required one staff to assist with transfers, however the Care Summary Report identified two staff for transfers. The Care Summary Report noted that the resident did not have an indwelling catheter however the Active Care Plan report included a catheter due to urinary retention. The plan did not give clear direction regarding transferring or urinary status.
E) The diet notes for resident #3007 stated modified diabetic, no added sugar, two grams sodium restriction diet. The resident confirmed that they order off of the regular menu and did not receive anything special. The current diet order on the Medication Administration Record (MAR), the plan of care and latest dietary assessment indicated a modified diabetic, regular diet with no mention of any sodium restriction.
F) The diet notes for resident #3009 and RD's nutritional assessment of April 18, 2013, indicated small portions. The requirement for small portions was not included on the resident's Active Care Plan.
G) The diet notes for resident #3010 indicated a scoop of protein powder at meals. This was not found on the resident's Active Care Plan Report or last nutritional assessment dated April 11, 2013. The plan did not give clear direction regarding nutritional care needs. (168)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :** Aug 30, 2013

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents, including residents #4007, #0986, #5000, #5001, #0015, #3006, #6003, #6006, #3004, #3003, #3002, #3001, #3012, #3013, #3014 and #2001, as specified in their plans of care.

Grounds / Motifs :

1. Previously issued as a CO and corrected April 2012 and as VPC in January 2013.

Not all care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #4007 had an order to discontinue foley catheter in one week and then complete in and out catheterizations every six hours, as needed for volume over 400 milliliters (ml), and to use the bladder scan if needed. The resident had the catheter removed as ordered and one bladder scan was completed on that date which identified that the resident was retaining urine. Staff did not fully assess the resident for a period of six days, when the resident returned to the hospital and was re-catheterized. The home maintained output records until the day following the removal of the catheter, however did not complete bladder scans to determine the volume of urine in the resident's bladder post urination and as a result were unaware if the resident required in and out catheterizations. Nursing staff interviewed confirmed that the home does have a bladder scanner and that this would be a method for staff to accurately assess the volume of residual urine in an individuals bladder.
B) The care set out in the plans of care related to hydration or nutritional need

for residents #0986, #5000, #0015, #3006, #6003, #6006, #3004, #3003, #3002, #3001, #3012, #3013 and #3014 were not provided to the residents when observed, or without intervention from the inspector.
C) The plan for resident #5000 included the treatment of hypoglycemia directions, dated July 11, 2011, which directed nursing to provide 10-15 grams of carbohydrate if the Capillary Blood Sugar (CBG) was less than four millimole/litre (mmol/l). The plan indicated that staff were to wait 15-20 minutes and then re-test the resident's blood sugar. If the results were less than four mmol/l then staff were to repeat the treatment however; if the results were greater than four mmol/l, staff were to provide the resident a meal (if within the hour) or a snack from the list of items indicated on the plan of care. Registered staff confirmed that if interventions were taken, documentation of this action would be in the resident's progress notes. The resident experienced blood sugars below four mmol/l on eight occasions between January and April 2013. Progress notes confirmed that the resident was not provided with interventions or follow up as directed in the plan.
D) The plan for resident #5001 indicated that the home was to provide consistent caregivers and all staff were to review care instructions before entering the room if they were unfamiliar with the resident's care. Staff interview confirmed that at least two of the three staff working days on March 25, 2013, were unfamiliar with the resident's care and routines. The resident and one staff member confirmed that the staff did not review the resident's care routines prior to initiating morning care. On March 25, 2013, registered staff entered the resident's room at 0700-0715 hours. The individualized routine indicated the resident did not wake up until later in the morning. The day staff confirmed that they were unable to understand and communicate with the resident when they provided morning care, that they were aware of the system in place to communicate with the resident but, were unable to state how to use the system as identified in the plan of care.
E) The plan for resident #2001 identified a pain assessment was to be completed every Tuesday on day shift. During the month of April 2013, a pain assessment was to be completed five times, however it was completed only three times. The resident was receiving a narcotic pain medication regularly and verbalized pain on several occasions. Staff confirmed the assessments were not completed. (168)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that residents, with changes in care needs, specifically related to: identified infections, new diagnoses, pain, reduced nutritional intake and wound care, including residents #2001, #9863, #0015 and #0986, are monitored, assessed, reassessed and their plans of care reviewed and revised to address the changes.
The plan is to be submitted by July 5, 2013 to lisa.vink@ontario.ca.

Grounds / Motifs :

1. Previously issued as a CO and complied with on April 2012 and as a VPC January 2013.

Not all residents were reassessed and the plan of care reviewed and revised with change in the care needs.

A) Resident #2001 experienced a change in care needs and the care was not reassessed or revised. A urine specimen report was received at the home in 2013, indicating a urinary tract infection. The report was not reviewed by the physician and the resident did not receive a change in the care. The resident was transferred to the hospital six days later, with sepsis, which was confirmed with the physician and nursing staff.
B) The plan for resident #2001 was not updated to reflect the changes in needs

after returning from hospital. The resident was admitted to the hospital. The resident returned to the home four days later. The plan was not updated to reflect the changes in health status. The plan completed on return from hospital, by dietary staff and nursing staff did not include tall of the current needs of the resident.

C) Resident #9863 was not reassessed related to pain when the care needs changed. The resident had a fall and fractures. The resident complained of pain, from the injury, the following day, and received increased narcotic medication 21 times over a 16 day period of time. The resident reported continued pain in the area when touched, with exacerbation when positioned. Staff confirmed the resident continued to complain of pain and it was now considered chronic. The weekly assessments, identified pain in the area but the plan was not revised. The pain plan identified the cause related to arthritis and an old fracture and did not identify the new fractures or include strategies to prevent pain in the area.

D) The current care plan for resident #0015 indicated that staff were to apply specific dressings as ordered. Progress notes of March 12, 2013, indicated that the physician had changed the dressing to another dressing. The plan indicated that the resident had a stage II ulcer, secondary to incontinence and a stage IV ulcer with a diagnosis. Registered staff confirmed on April 29, 2013, that the stage II ulcer was resolved and that the plan of care was not revised with changes in the residents skin care status.

E) Progress notes from November 2012, indicated that resident #0986 had poor oral intake with refusals to eat. The food and fluid intake form for November 2012, indicated the resident only consumed five breakfast meals for the entire month and refused or had no intake for at least 36 meals that month. Nursing initiated a referral for poor fluid intake on Nov 12 and Nov 20, 2012, as the resident had consumed five glasses or less of fluid 19 days in a row (November 6 until 25, 2012). The RD confirmed that not all referrals received related to hydration were completed and there was no reassessment of the resident completed as a result of these referrals. (141)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee shall ensure that when any resident is restrained by the use of a physical device, it is done so in accordance with section 31 or under the common law duty described in section 36 of the LTCHA.

Grounds / Motifs :

1. Not all residents in the home were restrained by the use of a physical device, other than in accordance with section 31 of the Act.

A) Resident #4000 was observed on April 29, 2013, to be in a wheelchair using a front fastening seat belt. The resident was not able to remove the belt on request and staff interviewed confirmed that the resident was not able to open the device. According to the clinical record the use of the belt was done so without an order, consent or monitoring records in place. This information was confirmed during staff interview.
B) Resident #4003 was observed to be wearing a front fastening clip style seat belt on April 29, 2013. The resident was unable to release the device on

request and the RPN interviewed reported that she did not believe the resident was able to remove the device on demand. The resident did not have a current order in place for the use of the device. The resident's order for a clip belt was discontinued on February 6, 2013, when a tilt chair was ordered as a Personal Assistance Service Device (PASD). The RPN confirmed that the resident did not have an order in place for the use of the device, which was being used.
C) Resident #0883 was not repositioned at least once every two hours when being restrained by a physical device. The resident was up in the wheelchair and a lap belt applied at 1130 hours, on April 30, 2013. The resident returned to the lounge at 1235 hours and was observed until 1409 hours. The belt was not released nor did staff reposition the resident during this time. Staff confirmed that the resident was last positioned at 1130 hours. The resident was observed up in the wheelchair with a lap belt applied on May 3, 2013, at 1020 hours until 1145 hours. The belt was not released and staff did not reposition the resident during this time. Staff confirmed that the resident was last positioned at 0915-0930 hours after morning care was provided.
D) Resident #4003 was observed on April 29, 2013, at 1050 hours, to be wearing a front closing clip style seat belt which was loosely applied around the abdomen. The belt was applied loosely allowing staff to easily insert one hand width between the resident's abdomen and the belt. The RPN interviewed confirmed that the belt was applied loosely and tightened the belt before contacting therapy services to review the application of the device.
E) On May 1, 2013, resident #0883 had a seat belt applied that was five inches from their pelvic crest. Three staff interviewed were unable to identify that the belt was applied loosely nor were they able to provide information on how tight or loose the belt should be applied. The DON confirmed that restraint education was completed August 13, 2012, and included direction for staff to apply seat belts with just enough space for two fingers to fit between the belt and the resident's pelvic crest. The staff interviewed did not complete the education and manufacturer's instructions were not available when requested.
F) On May 14, 2013, at 1444 hours, resident #5005 had a loose seat belt applied five inches from the pelvic crest. Registered staff confirmed that the belt was loose and tightened the belt on request of the inspector. Staff confirmed that the belt was a restraint. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :