Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 23, 2015	2015_448155_0025	021444-15	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
574 Northcliffe Avenue DUNDAS ON L9H 7L9

Long-Term Care Home/Foyer de soins de longue durée

ST JOSEPH'S HEALTH CENTRE, GUELPH
100 WESTMOUNT ROAD GUELPH ON N1H 5H8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 4 and 5, 2015.

This complaint inspection was done concurrently with the Resident Quality Inspection log number 027948-15 inspection number 2015_226192_0060.
This complaint inspection was conducted as a result of a complaint to the action line that indicated care was not provided.

During the course of the inspection, the inspector(s) spoke with Assistant Director of Care, Business Office Administration, Registered Practical Nurse and two Personal Support Workers.

During this inspection the inspector observed residents and staff-resident interactions; and reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received preventive and basic foot care services, that included the cutting of toenails, to ensure comfort and prevent infection.

Resident #001 did not receive preventive and basic foot care services that included the cutting of toenails, to ensure comfort and prevent infection.
The Assistant Director of Care confirmed that the toenails for resident #001 were long and that they had not been cut for a period of time.

As a result of this concern the Assistant Director of Care completed an audit of half of the resident's that resided in the same neighbourhood as resident #001. The audit revealed that 75% of the residents' audited did not have their foot care/toenails cut. As of November 4, 2015 there were no further audits done on the neighbourhood regarding foot care/cutting of toenails. This was confirmed by the Assistant Director of Care.

The licensee failed to ensure that each resident of the home received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provided direct care to the resident.

Resident #001 was admitted to the home. Interviews with two Personal Support Workers and a Registered Practical Nurse revealed that they provided nail care to residents based on a list posted on the bulletin board in the nursing station. This list indicated that Personal Support Worker staff were to provide nail care to all residents except the residents that were on the list. Resident #001's name was not on that list.
During an interview with one of the Personal Support Workers they shared that most of the residents in the neighbourhood had their toe nails cut by an external foot care provider.

During an interview with the Assistant Director of Care they indicated that each neighbourhood had a list that included all the residents that lived on the neighbourhood and that the list identified which residents were provided foot care by an external foot care provider. This list was not the list that the two personal support workers and Registered Practical Nurse referenced. This was confirmed by the Assistant Director of Care.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the residents. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee of a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

The home received an email complaint regarding the care of a resident.

A copy of the email complaint was reviewed by Inspector #155. The Assistant Director of Care confirmed that the written complaint was not forwarded to the Director. [s. 22.]

Issued on this 23rd day of November, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.