Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
May 10, 2016	2016_260521_0011	010577-16	Resident Quality Inspection

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

REBECCA DEWITTE (521), MELANIE NORTHEY (563), NATALIE MORONEY (610), RHONDA KUKOLY (213), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 27, 28, 29, 2016 and May 2, 3, 4 and 5, 2016.

The following inspections were completed concurrently with the Resident Quality Inspection:
Complaints logs:
#010385-16/ IL-43806-LO Pertaining to care issues linked with #001566-16/ IL-43806-

LO,
#008548-16/ IL-43606-LO pertaining to care conferences.

Critical Incident System logs:
#009643-15/ C564-000010-15 Pertaining to falls,
#013129-15/ C564-000014-15 pertaining to care,
#006976-16/ C564-000005-16 pertaining to prevention of abuse,
#007030-16/ C564-000006-16 pertaining to prevention of abuse,
#011687-15/ C564-000013-15 pertaining to alleged abuse,
#028399-15/ C564-000026-15 pertaining to alleged abuse,
#005826-16/ C564-000004-16 pertaining to alleged abuse,
#012059-16/ C564-000009-16 pertaining to prevention of abuse,
Follow up order #011647-16 pertaining to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrators, the Director of Care (DOC), the Assistant Director of Care (ADOC), three Registered Nurses (RN's), four Registered Practical Nurses (RPN's), fifteen Personal Support Workers (PSW's), one Program Lead, one Occupational Therapist (OT), one Dietary Aide, one Clinical Lead Recreation, two Receptionists, the Family Council Chair, both Resident's Council Presidents, over 40 residents and five family members.

During the course of the inspection, the inspector(s)toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes pertaining to resident and family council meetings.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_418615_0007	521

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

A complaint was reported to the home.

A review of the home's complaint log revealed there was no documented record of the complaint. The ADOC #100 and the DOC #103 both verbalized they were aware of the complaint.

A review of the home's policies ADMIN-002-1 and ADMIN-002-3 Client Compliments and Complaints, revealed "minor complaint – a more distinct criticism or concern where resolution is straightforward consisting of an explanation, clarification or simple apology. Tracking of minor complaints is not necessary". The home's policy failed to mention that a documented record was to be kept in the home.

As required by s.101.(1) of O.Reg 79/10 the licensee shall: Ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).
(2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).
(3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

An interview with the DOC #103 acknowledged that their policy did not meet all the applicable requirements under the Act related to keeping a documented record of the complaint. [s. 8. (1) (a)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response.

Record review of Critical Incident Systems report #C564-000013-15 revealed alleged verbal abuse may have occurred.

Staff interview with the Director of Care (DOC) #103 and the Assistant Director of Care (ADOC) #100 revealed this concern had been received by the home.

Record review of Critical Incident Systems report #C564-000026-15 and #C564-000004-16 revealed another two alleged abuses had been reported.

Record review of the home's complaint log revealed the above noted complaints were not logged in the complaint log.

Record review of the home's critical incident log revealed the above incidents of reported alleged abuse were logged as critical incidents of abuse/neglect.

Staff interview with the Director of Care (DOC) #103 revealed the home logged reports of alleged abuse in the critical incident log, not on the complaints log and that the home reviewed the complaints and critical incidents annually.

The home did not review or analyze complaints at least quarterly for trends to determine what improvements required in the home. [s. 101. (3)]

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 the documented record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements are required in the home; and a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Record review of the home's policy "Medication Administration - Hospital, Ambulatory Care, Outreach, Long Term Care #PHARM-019-1" revealed "Medications cannot be pre-poured (taken out of their labelled packaging) for administration at a later time".

Observations by Inspector #213 and Inspector #633 revealed four medications in resident's medication containers had been removed from the original package provided by the pharmacy provider.

Staff interview with #120 with Inspectors #213 and #633 revealed that medications in the medication cart had been removed from the original packaging provided by the pharmacy provider.

Staff interview with #110 with Inspectors #213 and #633 revealed that on that unit they had taken the medications out of the original box provided by the pharmacy provider to store them in the medication cart. [s. 126.]

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 drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy to promote zero tolerance of abuse and neglect of residents, and to shall ensure that the policy was complied with.

A Critical Incident Systems report #C564-000014-15 had been submitted by the home regarding an incident that resulted in a negative outcome.

A review of documentation showed that resident had a cognitive impairment.

A review of the Critical Incident Systems report under "What long term actions are planned to correct this situation and prevent recurrence" the home stated they would complete further staff education and amend their policy.

“The Zero Tolerance of Abuse and Neglect policy showed that all clients have the right to live and receive care in an environment that treats them with dignity, respect and is free from any form of abuse and neglect at all times, and in all circumstances”.

When asked, the DOC #103 replied “correct” if the resident had experienced the said incident.

A review of the Critical Incident Systems report confirmed the resident had experienced the said incident which did not comply with the home's Zero Tolerance of Abuse and Neglect policy. [s. 20. (1)]

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Issued on this 10th day of May, 2016

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

Original report signed by the inspector.