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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 15, 2017	2017_683126_0011	003596-17	Complaint

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St CORNWALL ON K6J 5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET CORNWALL ON K6J 5T2

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

LINDA HARKINS (126)

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): August 14, 15, 16, 17, 21, 28, 29, 30, 31, September 1, 5, 6, 7, 2017

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care (DOC) , the Infection Control Nurse, the Recreology Manager, the Patient/Resident Advisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Physiotherapist, one sitter, two family members and the resident.

During the course of this inspection, the inspector observed care and services given to the identified resident, reviewed the staff education history reports, reviewed the health care record of the identified resident, reviewed the audit report related to hand hygiene for an identified period and reviewed applicable policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from neglect by PSW #100.

As per O. Reg. 79/10, s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified day, the Substitute Decision Maker (SDM) visited resident #001 and observed that resident #001's two identified body areas were excoriated and were bleeding. The SDM also, observed dried stool between his/her buttocks. Resident #001's bed linen was observed to be soiled with dried blood and had not been changed.

The SDM notified the Supervisor for the PSW and an investigation started.

On August 17, 2017, the Director of Care (DOC) indicated to Inspector #126, that as part of the home investigation PSW #106 indicated the following: PSW #016 worked on a specified day from 2300-0700 hours and that resident #001 "was not changed all night" and related to the dry stool, PSW #106 indicated that he/she "did not pay as close attention as he/she should have". PSW #106 indicated that he/she thought that the plan of care was not to wake resident #001 during the night even if resident #001 required a changed of brief. The DOC, indicated that the written plan of care of that identified time was reviewed and no documentation was found indicating that resident #001 was not to be changed during the night. The DOC indicated that following the interview with PSW #106, she ensured that the night staff were aware that resident #001 was to be changed during the night if needed.

On August 21, 2017, the PSW's Supervisor indicated to Inspector #126 that the morning of that specified day, the SDM informed her of the concerns related to resident #001. She indicated that an investigation was immediately initiated and the PSWs that have worked the night shift were interviewed. The PSW's supervisor documented on "Work related Feedback Form" dated that specified day, that the SDM informed her that resident # 001's had two identified body areas excoriated and was bleeding. Also, there was dried stool between his/her buttocks and that the bed linen was soiled with dried blood and was not been changed". The following day, she interviewed PSW #106, who indicated that he/she did not report any excoriation to the nurse. [s. 19. (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 residents are protected from neglect, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the suspicion of neglect was immediately reported to the Director.

On a specified day, the Substitute Decision Maker (SDM) visited resident #001 and observed that resident #001's two identified body areas were excoriated and were bleeding. The SDM also, observed dried stool between his/her buttocks. Resident #001's bed linen was observed to be soiled with dried blood and had not been changed.

The SDM notified the management team the morning of the identified date and the management team initiated an investigation related to the concerns reported by the SDM.

On August 16, 2017, the DOC indicated to Inspector #126, that the incident of neglect was not reported to the Director at that time.

Resident #001 was neglected on a specified day and the incident was not reported to the Director. [s. 24. (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 any suspicion of neglect be reported to the Director,, to be implemented voluntarily.

WN #3: 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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff related to a skin treatment to an identified body area.

Resident #001 was admitted to the home on a specify date with several diagnosis. Resident #001 was known to have an altered skin integrity. Resident #001' s family expressed concerns about the treatment and the care that the resident was receiving regarding the altered skin integrity to an identified body area.

On August 17, 2017, the Director of Care (DOC) indicated to Inspector #126 that in response to the family concern about the application of medicated cream to the identified body area, that the order was changed on a specified day to ensure that nurses would be in charge of the application of the medicated cream.

On August 30, 2017, Personal Support Worker (PSW) #106 indicated to Inspector #126 that the medicated cream around resident's #001 body area was applied by the nurses.

On August 30, 2017, Registered Practical Nurse (RPN) #102 indicated that it was the nurses responsibility to apply the medicated cream to the identified body area and that they signed in the Medication Administration Record (MAR) when it was administered.

Inspector # 126 reviewed the plan of care of a specified date and there was no direction/interventions related to the altered skin integrity to the identified body area. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care that was set out in the plan of care was provided to resident #001 as specified in the plan.

Resident #001 was admitted to the home on a specified date with several diagnosis. Resident #001 requires total assistance for activity of daily living, including toileting on daily basis and continence product to be changed as required.

In the care plan of a specified date, under Incontinence care, requires staff to ensure resident #001 “wears “heavy wetting” (peach colored) attend for incontinence (urinary and bowel) day and night.”

On a specified date, the Substitute Decision Maker (SDM) arrived in the morning to assist with the care of resident #001 and observed that resident #001 was not wearing a brief under his/her clothing and had dry feces between the buttocks. The Management Team was notified and initiated an investigation.

On August 29, 2017, the Director of Care (DOC) indicated to Inspector #126, that she interviewed PSW # 106 on a specified date and implemented discipline measures related to the lack of care.

On August 30, 2017, Personal Support Worker (PSW) #106 indicated to Inspector #126 that he/she must have been distracted and pulled the resident's clothing up without applying the brief. PSW #106 indicated that since that incident he/she is now providing care to resident #001 in bed to ensure that resident #001 is properly clean.

On a specified date, PSW #106 did not apply a continence product and did not clean resident #001’s perineum properly as specified in the plan of care. [s. 6. (7)]

Issued on this 18th day of September, 2017

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

Original report signed by the inspector.