Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2019	2019_617148_0016	004716-19, 008698-19	Complaint

Licensee/Titulaire de permis

The Religious Hospitallers 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

AMANDA NIXON (148)

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): June 5, 6, 7, 10, 11 and 12, 2019

This inspection included two complaints: Log 004716-19 related to the care and services provided to resident #002,including responsive behaviours; and Log 008698-19 related to the admission of applicant #001.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Chief Nursing Officer, Resident and Patient Relations Advisor, Nursing Care Coordinator, Registered Nurse, Registered Practical Nurses, Resident Care Aides, residents and family members. In addition the Inspector spoke with staff from the Local Health Integration Network including the Placement Care Coordinator, Care Coordinator and Team Assistant.

The Inspector reviewed health care records of resident #002 and the application and assessment documents related to applicant #001. The Inspector also observed the resident's care environment, resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 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	Légende 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #002 was based on, at a minimum, interdisciplinary assessment of behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers with respect to the resident.

The admission Minimum Data Set (MDS) Assessment for resident #002 indicated the resident exhibits responsive behaviours. For the following three months post admission, progress notes and interviews with staff indicated that the resident routinely exhibited specific responsive behaviours. An incident occurred on a specified date, related to the resident's responsive behaviours which resulted in injury. The health care record indicated that medication was not effective in managing the behaviours and the resident was not easily redirected. The MDS Assessment indicated that both mood and behavior were to be care planned.

As a result of the MDS Assessment, the plan of care developed at the time of admission and in place for the following three months, included interventions for the resident's mood. The plan of care did not include goals, interventions or identified triggers for the identified responsive behaviours. After the incident occurred, as reference above, the mood plan of care was updated to include the monitoring of responsive behaviours. Nine days after the incident, a plan of care was added specific to responsive behaviours.

The licensee failed to ensure that the plan of care was based on an assessment resident #002, specific to identified responsive behaviours. [s. 26. (3) 5.]

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 plan of care for a resident is based on, at a minimum, interdisciplinary assessment of behaviour patterns, including wandering, any identified responsive behaviours and any potential behavioural triggers with respect to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care; and an explanation of how the supporting facts justify the decision to withhold approval.

In accordance with section 44 of the LTCHA and O. Regulation 79/10 section 162 the placement coordinator shall ensure that any assessment given to the licensee was made within the previous three months. As described by section 44 and O. Regulation 79/10 section 184, if information provided to the licensee by the placement coordinator indicates that there has been a change in the applicant’s condition and as a result a ground for withholding approval exists under section 44(7) of the LTCHA, the licensee may withdraw the approval of the applicant’s admission to the long there care home.

On a specified date, the Resident and Patient Relations Advisor provided applicant #001 with a written notice indicating that the licensee lacked the nursing expertise and physical facilities necessary to meet applicant #001’s care requirements. The letter indicated that the most recent assessment suggested the applicant exhibited behaviours of anger, verbal and physical abuse and an altercation with another individual. The written notice indicated that the applicant may be a potential harm to others and for these reasons, it would be ill advised to have the applicant admitted to the home where frail elderly individuals could face a risk of harm.

Applicant #001 was accepted to the long-term care home’s wait list in 2013, at which time the applicant's assessment information provided by the placement coordinator indicated the applicant exhibits behaviours of anger; the potential risk to others was described as behavior not present. The most recent assessment available to the licensee was three months prior to the issuance of the written notice. The most recent assessment indicated the applicant exhibits behaviours of anger; the potential risk to others was described as behavior not present. The most recent assessment described an increased frequency of behaviours.

Inspector #148 discussed the applicant and the withdrawal of approval with the Resident and Patient Relations Advisor (Advisor). When asked in what way the long-term care home lacked the nursing expertise and physical facilities to meet applicant #001’s care requirements, the Advisor described that applicant #001 would require the expertise of nursing staff located on the secure unit of the home, however, believed that applicant #001 would not be well suited for the secure unit as the applicant did not require such security measures and continued to visit community members independently. Further to this, the Advisor said that applicant #001 would not be suited for other units in the home as the applicant required increased staff assistance, which may not be available on these units. Upon discussion, the Advisor did not describe an incident whereby the applicant had caused harm to others, however, noted that the potential to harm others existed. With regards to the referenced physical altercation with another individual, it was established that this incident occurred six months prior to the issuance of the written notice whereby the description of the incident indicated that the applicant had not caused harm.

The written notice did not provide for a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care or an explanation of how the supporting facts justify the decision to withhold approval. [s. 44. (9)]

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.