Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'Inspection
Oct 23, 24, 25, Nov 19, Dec 6, 7, 2012	2012_140158_0021	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'Inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care (DOC), Dietitian, Food Service Supervisor, Registered Nursing Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed care and service delivery to residents by staff, reviewed a resident's health care record, reviewed various policies and procedures, and reviewed the home's continence care and bowel management program.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 did not ensure that the resident, the SDM, if any, and the designate of the resident/SDM were given an opportunity to participate fully in the development and implementation of the plan of care. The health care record, including the progress notes for resident # 01 was reviewed by the Inspector on October 24, 2012.
It was first documented, three months ago in the progress notes, that other residents' responsive behaviours caused resident # 01 to become anxious and fearful. The substitute Decision Maker's (SDM) suggestion regarding interventions to manage resident # 01 anxiety was documented in resident # 01 progress notes, however, the behaviour and the suggested interventions were not documented in the plan of care.
A change to resident # 01 medication regime was ordered by the physician in 2012. The SDM stated to the Inspector that the home did not inform them of the addition of a medication. The home's policy "Substitute Decision Maker" acknowledges that the SDM has the authority to make decisions about the resident's care and treatment and that "communication with the SDM, as well as attempts to reach the SDM, are documented in the resident's progress notes". No documentation was found in resident # 01 progress notes identifying that the SDM was notified. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (5)]
2. The licensee did not ensure that the care set out in the plan of care was provided to resident # 01 as specified in the plan of care. The October 2012 fluid sheets for resident # 01 were reviewed by the Inspector on October 24, 2012 and it is documented that the resident's daily fluid requirement as assessed by the dietitian was not provided to the resident for nine days. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (7)]
3. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to resident # 01. The resident's admission nutritional assessment was completed by Staff # S-102, who identified that resident # 01 required a specific diet and texture, as well as, a specific amount of fluids per day.
On October 25, 2012, the Inspector reviewed the kardex, the flow sheets and the plan of care for resident # 01. The kardex for resident # 01 did not reflect Staff # 102 assessment of the resident's fluid requirement. The plan of care for resident # 01 did not identify the resident's assessed diet or the resident's assessed fluid requirement. The plan of care did not set out clear directions to staff and others who provide direct care to resident # 01. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]
4. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care for resident # 01. The health care record, including the progress notes for resident # 01 was reviewed by the Inspector on October 24, 2012. It was first documented three months ago in the progress notes, that other residents' responsive behaviours caused resident # 01 to become anxious and fearful. Interventions to manage the resident # 01 behaviour were also documented in the progress notes, however, the behaviour nor the interventions were documented in the plan of care. Staff S-100 stated to the Inspector on October 24, 2012 that they were not even aware that resident # 01 had any behaviours. The plan of care did not set out clear directions to staff and others who provide direct care to resident # 01. [LTCHA 2007, S.O. 2007, c. 8, s. 6 (1)(c)]

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 ensuring that the resident, the SDM, if any, and the designate of the resident/SDM are given an opportunity to participate fully in the development and implementation of the plan of care, ensuring that the care set out in the plan of care is provided to residents and ensuring that the plan of care sets out clear directions to staff and others who provide direct care for residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee did not ensure that no medical directive or the order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and need. The health record, including the progress notes, the Medication Administration Record (MAR), and the physician's orders for resident # 01 was reviewed by the Inspector on October 24, 2012. Resident # 01 had 14 days of nausea with periodic episodes of vomiting. Resident # 01 MAR shows that the resident received an anti-emetic medication on seven separate occasions. The progress notes identified that the home's medical directive for the anti-emetic was used on these seven separate occasions. The physician's orders were reviewed and there is only one documented entry of the medical directive written and individualized. The home's policy for medical directives was reviewed and the procedure identifies that for each use of a medical directive, the Registered staff are to write out in its entirety the physician's order on the resident's physician's order sheet. The order is then transcribed by 2 registered staff and the order is transcribed on the MAR and a notation in the resident's progress notes regarding the usage and effectiveness of the medical directive is documented. The medical directive used was not individualized. [O Reg. 79/10, s. 117. (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every 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).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of the resident is investigated and resolved where possible and a response that complies with paragraph 3 provided within 10 business days. The health care record, including the progress notes for resident # 01 was reviewed by the Inspector on October 24, 2012. Although there were three separate documented acknowledgements that a complaint was brought forward to the Registered staff regarding other residents' responsive behaviours causing resident # 01 anxiety, it is not documented in the progress notes, whether the complaint was investigated or whether the matter was resolved. The complainants stated to the Inspector on October 24, 2012 that they have not been approached, questioned or provided with a response regarding their complaint.
The Inspector spoke with Staff # S-104 on October 24, 2012, who identified that when a family comes forward with a verbal concern, the matter is looked into by them or someone they delegate it to and that the documentation of the concern and its investigation is written in the resident's progress notes. Staff # S-105 identified to the Inspector that when a resident's or family's verbal complaint/concern is looked into and if the RN is unable to rectify the problem, it is then referred to the DOC. Any intervention by the Registered staff is documented in the resident's progress notes. Staff # S-100, Staff # S-101 and Staff # 103 were interviewed on October 23 and 24, 2012. Each discipline identified that they would try to manage the concern themselves and if unable to rectify the issue, they would then report it to the Registered staff. At no time did any discipline identify that issues are reported to their respective manager.
The home's policy "Concerns/Complaints" states that "all concerns and suggestions are referred to the appropriate manager for review". Although, there is a specific protocol to follow if the complaint or concern is written, there is no clear direction given when the concern/complaint is verbal. [O Reg 79/10, s. 101. (1) 1]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management
Specifically failed to comply with the following subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on an assessment and that the plan is implemented. The health care record, including the progress notes, MDS assessments and the plan of care for resident # 01 was reviewed by the Inspector on October 24, 2012. Resident # 01 admission assessment identified that the resident was incontinent. The resident's plan of care identified that the resident was on a toileting schedule and was to wear a specific size and type of continence product. On October 25, 2012, the Inspector observed that resident # 01 was wearing a different type and size of continent product than what was identified on their plan of care. The Inspector also noted that the continence care supplies stored in the resident's bathroom were not the products identified in the plan of care.
On October 24, 2012, resident # 01 was escorted off the unit by a staff member to have other services rendered. It was observed by the Inspector that the resident was not toileted or checked for wetness prior to leaving the unit. The resident returned to the unit 30 minutes later and proceeded to their room without being toileted or checked for wetness. The resident was not toileted as directed in the plan of care. The plan to manage the resident's urinary continence was not implemented. [O Reg. 79/10, s. 51 (2) (b)]

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 ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on an assessment and that the plan is implemented, to be implemented voluntarily.

Issued on this 7th day of December, 2012

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