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

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

Hamilton Service Area Office
119 King Street West 11th Floor
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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 27, 2014	2014_250511_0020	H-001096-14	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 16 and 17, 2014

Critical Incident #2975-000028-14

During the course of the inspection, the inspector(s) spoke with the Director of Care, Associate Director of Care, Resident Care Coordinator, Registered staff, Health care Aides(HCA), resident and resident family member

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had not ensured that the following rights of resident #001 were fully

respected and promoted: 4. Every resident had the right to be properly cared for in a manner consistent with his or her needs.

Resident #001 was had a history of numerous falls since their admission date in 2014. In a month in 2014, resident #001 sustained a fall where they were witnessed by a Health Care Aide (HCA) to have fallen at the bedside. The Fall progress notes indicated the resident was assessed by a Registered Practical Nurse (RPN), on the floor of their room and had no injuries. Documentation, by the RPN, included the resident complained of pain and was assisted to a standing position by two other Health Care Aids (HCA) and placed back to bed. The documentation indicated pain medication was given once for pain with poor effect by the RPN.
The resident remained in bed until they were reassessed by a Registered Nurse (RN), as a follow-up to the earlier fall, approximately an hour and a half since their initial fall. The RN documented that when they assessed the resident they noted a large laceration. The resident was documented as being in considerable pain during the assessment and stated they were in the worst pain they had ever been in. The RN documented the resident was observed to have a suspected fracture. The RN immediately called for an ambulance and resident #001 was treated at hospital for the laceration and a confirmed fracture.

Interview with the RPN, who responded to the resident's fall, stated they had not normally worked on this floor, was not scheduled to work on this floor the night of the fall, did not know the resident' care needs and was only on the floor for a brief moment to count medications with the RN assigned to this floor. The RPN stated they went to assess resident #001 when the HCA stated the resident had fallen. The RPN indicated they had knowledge the resident had fallen but confirmed they had not completely assessed the skin condition of resident #001. This was confirmed by an interview with the HCA, who was also present at the time of the nursing assessment. The RPN also stated they did not complete the Head-to-Toe assessment of the resident's skin condition once they were in bed. The RPN stated they reported to the oncoming RN, assigned to the resident, that resident #001 had fallen and had been given pain medication.

Interview with the DOC confirmed resident #001's care needs, in relation to their fall in 2014, would have included the need for a complete Head-to-Toe assessment, immediate treatment and pain control for any injury sustained from the fall. The DOC confirmed the home did not ensure resident #001's right to be properly cared for in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A review of the home's Falls Prevention and Management policy, NUR-POL/3, revised October 23, 2013 indicated the following:

1. Registered staff will collaborate with residents' /POA/Substitute decision-makers (SDM) and family and interdisciplinary team to conduct a fall risk assessment within 24 hours of admission and quarterly and when a change in health status puts them at risk for increased risk for falling.
2. Registered staff will monitor every hour for the first 4 hours and then every four hours for 24 hours post fall for signs of neurological changes and if there is suspicion or evidence of injury the resident is not to be moved until a full Head-to-Toe assessment is conducted and appropriate action determined.
3. Registered staff will arrange a care conference for residents who have frequent falls.

Resident #001 was admitted in 2014 with a history of having more than ten falls in the

community in the year prior to admission. The resident sustained numerous falls from the time of admission to the time when they sustained a fall causing a fracture. The resident had a number of these falls in one month in 2014. The resident had a change in their medical condition during this same month in 2014 that may have precipitated these falls. A review of resident #001's clinical record did not identify the completion of any falls risk assessments. Interview with the MDS RAI Coordinator confirmed a falls risk assessment was not completed on admission, quarterly or at the time of the change in condition, which would have constituted a change in the resident’s health status that placed them at an increased risk for falling.

A review of the registered practical nursing note dated in a month in 2014 indicated the resident had fallen in their room and was found on the floor beside their bed. The resident was assessed by the RPN, assisted back into bed by the staff and was next assessed by the Registered Nurse (RN). Interview with the RPN indicated she was not scheduled to work on this floor and had only come down to complete a medication count with the RN before returning to her own floor. The RPN stated she reported the fall to the RN and returned to her assigned floor. The RPN confirmed she did not reassess the resident as she had returned to her floor and stated that resident #001 was not assessed as per the home's policy.

A review of the clinical records confirmed the last care conference for resident #001 was documented as the six week post admission conference. Interview with family member (POA) indicated they would have liked a conference to discuss the frequent falls with the team, and that the registered staff had not arranged a care conference to review the numerous resident's fall. [s. 8. (1) (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 to ensure that where the Act or this Regulation require the licensee of a long-term care home to have, instituted 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, (b) is complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessment reassessment, interventions and the resident's responses to intervention were documented.

A review of the home's Falls Prevention and Management policy, NUR-POL/3, revised October 23, 2013 indicated the interdisciplinary team would conduct an interdisciplinary care conferences to determine the possible cause of falls and develop changes to prevent reoccurrence based on a quality improvement methodology of Plan, Do, Study, Act. Interview with the Resident Care Coordinator (RCC) confirmed the interdisciplinary care team met on the resident's floor twice a month but did not document these meetings. There were no documentation notes in the resident's clinical record for these meetings or changes to the plan of care to prevent reoccurrence of falls. Interview with the DOC confirmed the licensee did not ensure that any actions taken with respect to a resident under a program, including assessment reassessment, interventions and the resident's responses to intervention were documented. [s. 30. (2)]

Issued on this 3rd day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROBIN MACKIE (511)
Inspection No. / No de l'inspection :	2014_250511_0020
Log No. / Registre no:	H-001096-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 27, 2014
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
LTC Home / Foyer de SLD :	ST JOSEPH'S VILLA, DUNDAS 56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	David Bakker

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure residents, specifically resident #001, are cared for in a manner consistent with his or her needs. When a resident falls they will receive a complete Head-to-Toe assessment to determine injuries and where pain or injuries are identified the home will ensure these care needs are addressed immediately.

Grounds / Motifs :

1. The licensee had not ensured that the following rights of resident #001 were fully respected and promoted: 4. Every resident had the right to be properly cared for in a manner consistent with his or her needs.

Resident #001 was had a history of numerous falls since their admission date in 2014. In a month in 2014, resident #001 sustained a fall where they were witnessed by a Health Care Aide (HCA) to have fallen at the bedside. The Fall progress notes indicated the resident was assessed by a Registered Practical Nurse (RPN), on the floor of their room and had no injuries. Documentation, by the RPN, included the resident complained of pain and was assisted to a standing position by two other Health Care Aids (HCA) and placed back to bed. The documentation indicated pain medication was given once for pain with poor effect by the RPN.

The resident remained in bed until they were reassessed by a Registered Nurse (RN), as a follow-up to the earlier fall, approximately an hour and a half since their initial fall. The RN documented that when they assessed the resident they noted a large laceration. The resident was documented as being in

considerable pain during the assessment and stated they were in the worst pain they had ever been in. The RN documented the resident was observed to have a suspected fracture. The RN immediately called for an ambulance and resident #001 was treated at hospital for the laceration and a confirmed fracture.

Interview with the RPN, who responded to the resident's fall, stated they had not normally worked on this floor, was not scheduled to work on this floor the night of the fall, did not know the resident' care needs and was only on the floor for a brief moment to count medications with the RN assigned to this floor. The RPN stated they went to assess resident #001 when the HCA stated the resident had fallen. The RPN indicated they had knowledge the resident had fallen but confirmed they had not completely assessed the skin condition of resident #001. This was confirmed by an interview with the HCA, who was also present at the time of the nursing assessment. The RPN also stated they did not complete the Head-to-Toe assessment of the resident's skin condition once they were in bed. The RPN stated they reported to the oncoming RN, assigned to the resident, that resident #001 had fallen and had been given pain medication.

Interview with the DOC confirmed resident #001's care needs, in relation to their fall in 2014, would have included the need for a complete Head-to-Toe assessment, immediate treatment and pain control for any injury sustained from the fall. The DOC confirmed the home did not ensure resident #001's right to be properly cared for in a manner consistent with their needs. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Robin Mackie

Service Area Office /
Bureau régional de services : Hamilton Service Area Office