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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 5, 2016	2016_449619_0025	003041-16	Complaint

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

SAMANTHA DIPIERO (619)

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): July 21, 25, 26, 2016.

The following complaint inspection was conducted:

#003041-16 related to skin and wound care, transferring and positioning, medication administration, and the provision of care.

During the course of the inspection, the inspector(s) spoke with the President, Chief Nursing Executive (CNE), Assistant Director of Care (ADOC), Nursing Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs), Behavioural Support Unit Representative, identified residents and family members. The Inspector also toured the home, observed the provision of care, and reviewed the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Personal Support Services
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)**

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. 6. Plan of care

Specifically failed to comply with the following:

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 :

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #001 was required to wear specialized medical garments daily for the treatment/management of a chronic condition. A review of the resident's written plan of care last updated in August 2015, indicated that the resident required assistance from two staff members to apply the specialized medical garment in the morning and remove them in the evening. It was noted by family members that the resident's garments were not applied, or, applied incorrectly, on more than one occasion. Interview with PSW #105 stated that the resident typically received assistance from a single care provider but required assistance from two home staff to manage behaviours while providing care. PSW #105 confirmed that staff have on occasion forgotten to apply or remove the medical garment as directed in the written plan of care. Interview with registered staff #104 indicated that because the medical garment was ordered by the physician are prepared for use by the registered staff, that it should be monitored daily to ensure the garment is being applied correctly. A review of the resident's progress notes identified by staff admission that staff did not apply the resident's specialized medical garment in the morning on two identified dates in March 2016, and on an identified date in April 2016, and did not remove the medical garment in the evening on an identified date in May 2016. Interview with Director of Nursing Care (DOC) confirmed that staff are expected to apply and remove all ordered medical garments for the resident on a daily basis and that staff failed to provide care as specified in the written plan of care.

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 with s. 6. (7) where the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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 :

The licensee failed to ensure that the plan, policy, procedure, strategy or system, was complied with.

Resident #001 had an altered level of cognition, and responsive behaviours. A review of the written care plan last updated September 2015, stated that the resident was to receive all medications in their room. According to registered staff #104 the resident did not typically display medication hoarding behaviours. The resident's plan of care, updated August 2015, indicated that the resident preferred, and was capable of, receiving their medications in whole form with supervision from staff. On an identified date in October 2015, the resident's family found three pills in the resident's mobility device and on their floor. An interview with the family indicated that staff were made aware of the pills in the resident's room, an interview with the DOC confirmed this. A review of the resident's health record was completed and revealed that this incident was not documented. A review of the progress notes on an identified date in July 2016, indicated that the resident's visitor located one tablet of medication on the floor in the resident's room and registered staff were made aware of the found medication. The home's medication policy titled "Medication Administration Rounds", last reviewed July 2013, stated registered staff must "Administer medications to resident ensuring the resident swallows them, unless there are physician's orders to leave meds at bedside" and should a resident refuse a medication staff are to "document why the dose was not administered in the progress notes of the resident's health record." Interview with RPN #104 indicated that the resident had a history of refusing care and that registered staff are required to ensure that when a resident consents to consuming medication that the medication is taken completely. RPN #104 indicated that the resident was not supervised adequately when receiving medications because that the staff did not ensure the resident consumed all of their medications and indicated that if a medication was not taken, the staff are to note this in the resident's Medication Administration Record (MAR). A review of the resident's MAR for the month of October 2015, and for the month of July 2016, indicated that the resident did not refuse any of their ordered medications. Interview with the Chief Nursing Executive (CNE) confirmed that the staff did not ensure that the resident consumed all of the medications that were to be administered and did not comply with the home's medication administration policy.

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 with r. 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #001 was identified as having a high risk of skin injury. A review of the physiotherapy assessment indicated that the resident was able to stand on their own with assistance from one staff member. A review of the resident's written plan of care updated August 2015, advised staff to "handle joints carefully; [resident's] skin is prone to [injury]. Do not grab on or hold [resident's] limbs when transferring but hold out arm and [resident] will grab the arm that is held out and get up from chair, bed, or commode." An interview with the family and review of the resident's health record indicated that on an identified date in January 2016, the resident obtained an injury on the left wrist and upper left arm during the provision of morning care. PSW #105 indicated that they assisted the resident to stand by holding the resident's arms to steady the resident. PSW #105 indicated that the plan of care stated that the resident was able to stand independently and required staff to offer their hand to the resident for balance and did not require any pulling or hoisting from the wrists or under the arms. PSW #105 confirmed that they did not assist the resident as per the written plan of care. In an interview, both registered staff #103 and PSW #105 indicated that the resident was to be transferred only with assistance in the form of offering an arm for the resident to hold on to while they rose from a seated position. PSW #105 stated that the resident would appear at time to need assistance to rise from a seated position, staff would physically assist the resident to stand but the resident's skin is very fragile so staff now provide their arm for support and allow the resident to stand on their own. A review of the home's policy titled "Lifts, Transfers, and Repositioning", last reviewed December 2015, policy #POL/5 stated "A resident handling technique will be identified for each resident on their plan of care …..Staff must adhere to the designated lift/transfer status as identified on each resident's care plan". Interview with the CNE confirmed that the staff did not adhere to the resident's transfer status as per the plan of care and that the staff did not use safe transferring techniques when assisting resident #001.

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 with r. 36. where every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Resident #001 had a history of cognitive impairment and responsive behaviours. The resident's family identified that coloured medical gloves worn by the home's staff were a trigger for the resident; this was included in the resident's written plan of care last updated in August 2015. The family provided colourless gloves to the home for use specifically with resident #100 to help reduce the resident's responsive behaviours which included being resistive to care, when care was being provided. Family members observed that coloured gloves employed for use by the home, were being left in the resident's waste basket, on two noted occasions including identified dates in May 2016, and June 2016 and expressed concern that these types of gloves were continuing to be used by staff when providing care for the resident. Interview with PSW #105 indicated that staff comply with the resident's requirement for colourless gloves worn but indicated that some PSW staff had provided care to the resident while wearing the coloured gloves provided by the home even when colourless gloves were available in the resident's room as provided by the resident's family. PSW #105 was unable to recall specific dates of usage of coloured gloves and declined to identify the PSW staff who used coloured gloves. RN #104 indicated that the resident received a behavioural assessment from the Social Worker and the Behavioural Support Ontario (BSO) Nurse and identified that the resident could become agitated or distressed when coloured gloves were used by staff. Interview with the Executive Nursing Director confirmed that staff did not consistently implement the identified responsive behaviours strategies when providing care to the resident.

Issued on this 11th day of October, 2016

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

Original report signed by the inspector.