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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Aug 22, 2019	2019_555506_0006	014636-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

LESLEY EDWARDS (506)

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 6, 7, 8, 9, 12, 13, 14, 15 and 20, 2019.

Complaint Log #014636-19- related to abuse and neglect, medication administration, skin and wound care, responsive behaviours and personal support services.

This inspection was completed concurrently with Critical Incident Inspection #2019_555506_0005.

Non compliance related to Ontario Regulation 79/10 s. 6 (7) identified during this inspection of log #014636-19 will be included in inspection report #2019_555506_0005 and issued as a written notification.

Non compliance related to Ontario Regulation 79/10 s. 53 identified during this inspection will be issued on inspection report #2019_555506_0005 and issued as a voluntary plan of correction.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Cares (DOC), Assistant Director of Care (ADOC), Physiotherapist, physiotherapy assistants registered nurses (RN), registered practical nurses (RPN), Local Health Integration Network (LHIN) Care Coordinator, Convalescent Care Lead, personal support workers (PSW), residents and families.

During the course of the inspection, the inspector observed the provision of care and services, medication administration, reviewed clinical records,policies and procedures and conducted interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 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	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. 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 has licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in June 2019, resident #006 was noted to have a change in their condition. The physician was called and assessed the resident and provided orders to the licensee.
A. A review of the clinical record confirmed that on an identified date in June 2019, confirmed that there was no assessment of the resident documented. An interview with RPN #147 on an identified date in August 2019, confirmed that they did completed an assessment of the resident but did not document this assessment.
B. A review of the clinical record confirmed that on an identified date in June 2019, confirmed that RPN #144 called the physician and received new orders for resident #006; however, there was no documentation in the progress notes to say that the physician had been called because of a change in the resident. In an interview with RPN #144 on an identified date in August 2019, they confirmed that they did complete an assessment but they did not document this.
C. A review of the clinical record on an identified date in June 2019, did not include any documentation of the resident. Interview with RPN #144 on an identified date in August 2019, they did assess the resident and there were no changes at that time; however, did not document their assessment.
D. A review of the clinical record on an identified date in July 2019, did not include any documentation of the resident. Interview with RPN #147 on an identified date in August 2019, they could not confirm if they assessed the resident as they did not document their assessment.
E. A review of the clinical record on an identified date in July 2019, did not include any

documentation of the resident. Interview with RN #133 on an identified date in August 2019, confirmed that they did complete an assessment of the resident and they found there were no changes to the resident's condition from the previous assessment, but they did not document this in the resident's clinical record.
F. A review of the clinical record on identified date in July 2019, did not include any documentation of the resident. Interview with RPN #147 on an identified date in August 2019, they could not confirm if they assessed the resident as they did not document their assessment.
G. A review of the clinical record on an identified date in July 2019, did not include any documentation of the resident's status. Interview with RN #143 on an identified date in August 2019, confirmed that they assessed the resident; however, did not document their assessments. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

The clinical record identified that resident #006 was admitted to the home on an identified date in April 2019, with areas of altered skin integrity. Interview on an identified date in April 2019, with staff #132 confirmed that resident #006's areas of altered skin integrity were not assessed by a member of the registered nursing staff within 24 hours of admission. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound, received a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

A. A review of the clinical record for resident #006, identified that the resident had an area of altered skin integrity. A review of the clinical record did not include an assessment of the area. On an identified date in August 2019, staff #132 confirmed that they would expect an initial skin assessment to be completed and the resident did not have an assessment for the identified areas of altered skin integrity completed.
B. A review of the clinical record for resident #006 on an identified date in June 2019, identified that resident #006 had a new area of altered skin integrity. A review of the clinical record did not include an assessment of the areas of altered skin integrity using a clinically appropriate assessment. On an identified date in August 2019, staff #132 confirmed that the resident did not have an assessment for the identified areas of altered skin integrity completed, as required when the areas were first identified using a clinically appropriate assessment instrument.
C. A review of the clinical record for resident #006 on an identified date in June 2019, identified that resident #006 had a new area of altered skin. A review of the clinical record did not include an assessment of the area of altered skin integrity using a clinically appropriate assessment. On an identified date in August 2019, staff #132 confirmed that the resident did not have an assessment for the identified area of altered skin integrity completed. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian (RD) who was a member of the staff of the home, and that any changes made to the plan of care related to nutrition and hydration were implemented.

Interview with the RN #133 on an identified date in August 2019, verified that residents with new areas of altered skin integrity would be referred to the RD for assessment and that an electronic referral would be submitted to the RD in Point Click Care (PCC).

A review of the clinical record identified that resident #006 had new areas of altered skin integrity identified. There was no documentation in the clinical record of a referral to the RD of the new areas of altered skin integrity or an assessment completed. Staff #132 confirmed on an identified date in August 2019, that there was not a referral to the RD and this should have been completed when the resident developed new areas of altered skin integrity. [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff.

A. Resident #006 was identified with an area of altered skin integrity, review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. In an interview on an identified date in August 2019, staff #132 confirmed that the weekly assessment was not completed for resident #006.
B. Resident #006 was identified with an area of altered skin integrity and a review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. In an interview on an identified date in August 2019, staff #132 confirmed that the weekly assessment was not completed for resident #006.
C. Resident #006 was identified with an area of altered skin integrity and a review of the clinical record did not include a reassessment of the area of altered skin integrity on a weekly basis. In an interview on an identified date in August 2019, staff #132 confirmed that the weekly assessment was not completed for resident #006.
D. Resident #006 was identified as having an area of altered skin integrity, an initial assessment was completed on an identified date in June 2019, at the home. A weekly skin assessment was not completed on this area again. Staff #132 confirmed that the weekly assessment was not completed for resident #006. [s. 50. (2) (b) (iv)]

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 staff complete skin and wound assessments within 24 hours of admission, newly identified wounds, weekly skin and wound assessments and was assessed by the registered dietitian, to be implemented voluntarily.

WN #3: 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, institute or otherwise put in place any policy, the policy was complied with.

Ontario Regulation 79/10 s. s. 48(1) 3 states, "The licensee shall ensure that written policies and protocols are developed for the continence care and bowel management to promote continence and to ensure that residents are clean, dry and comfortable".

Specifically, staff did not comply with the licensee's policy "Ostomy Care", section Nursing Standards (dated January 2017), which required staff to report treatment, condition of skin, stoma characteristics and character, amount of drainage and include all pertinent observations.

An interview with staff #133 on August 14, 2019, confirmed the staff did not follow the licensee's policy for ostomy care and document pertinent observations. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not charged for goods and services that the licensee was required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network.

A complaint log #014636-19 was made to the Director regarding resident #006 having to supply their own products while they resided at the home. A review of the clinical record confirmed the resident was providing their own supplies. Interview with staff #132 on an identified date in August 2019, confirmed that the resident did provide their own products. The licensee failed to ensure that resident #006 was not provided goods and services that the licensee was required to provide to residents under the Long Term Care Home Service Accountability Agreement between the licensee and the Ministry or between the licensee and a local health integration network. [s. 245. 1.]

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.