Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 7, 2024
Original Report Issue Date: May 21, 2024
Inspection Number: 2024-1458-0002 (A1)
Inspection Type: Complaint Critical Incident
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas

Amended By Stephany Kulis (000766)	**Inspector who Amended Digital Signature** Stephany Kulis (000766)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #002 was amended to correct resident numbers.
Compliance Order #001 in this report for reference; however, were not amended.
As discussed with the home, the Compliance Due Dates (CDD) for both orders will remain. There were no changes made to the content of the amended public report.

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Lead Inspector Stephany Kulis (000766)	**Additional Inspector(s)** Lesley Edwards (506) Leah Curle (585)
Amended By Stephany Kulis (000766)	Stephany Kulis Digitally signed by Stephany Kulis Date: 2024.06.13 09:26:08 -04'00'

AMENDED INSPECTION SUMMARY

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Compliance Order (CO) #002 was amended to correct resident numbers.
Compliance Order #001 in this report for reference; however, were not amended.
As discussed with the home, the Compliance Due Dates (CDD) for both orders will remain. There were no changes made to the content of the amended public report.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 10-12, 15, 16, 18, 19, 22-25, 2024

The following compliant intakes were inspected:
· Intake: #00109560 - Compliant related to resident care and services, falls prevention and management, skin and wound care, and pain management.
· Intake: #00110010 - Complaint related to resident care and services and nutritional care.
· Intake: #00111087 - Complaint related to responsive behaviours.
· Intake: #00111569 - Complaint related to nutritional care.

The following Critical Incident (CI) intakes were inspected:
· Intake: #00106592 - CI# 2975-000009-24 - related to prevention of abuse and neglect.
· Intake: #00107325 - CI# 2975-000014-24-related to prevention of abuse and neglect.
· Intake: #00108273 - CI# 2975-000019-24 -related to resident care and support services.
· Intake: #00109173 - CI# 2975-000026-24 - related to disease outbreak.
· Intake: #00110750 - CI# 2975-000033-24 - related to fall prevention and management.
· Intake: #00111123 - CI# 2975-000037-24 -related to prevention of abuse and neglect.
· Intake: #00112035 - CI# 2975-000039-24 - related to resident care and support services.

The following intakes were completed in this inspection: Intake: #00109559 - CI# 2975-000030-24 and Intake: #00108146 - CI# 2975-000017-24 were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident's plan of care specified that they were to wear an indicator to identify violence risk. The resident was not wearing their indicator. A registered staff acknowledged that the resident was to have the indicator on and at times the resident had removed it.

The staff immediately applied a new indicator

Sources: Record review of a resident; observation of a resident, and interview with staff. [506]

Date Remedy Implemented: April 12, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident's plan of care specified that they were to wear an indicator to identify violence risk. The resident was not wearing their indicator. Resident Care Manager (RCM) acknowledged that the resident was to have the indicator on and at times the resident had removed it.

The RCM immediately applied a new indicator.

Sources: Resident observations and review of clinical records; and interview with RCM. [000766]

Date Remedy Implemented: April 22, 2024

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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.

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care related to certain care needs.

Rationale and Summary
A resident's clinical record noted they experienced certain care patterns related to their diagnosis. A staff reported the resident exhibited cues when they required certain care needs. The resident's written plan of care, including their care plan and kardex, did not include description of cues, which was confirmed by a RCM.

Failure to include the care needs in the written plan of care increased risk for the resident to experience greater incidents of care patterns.

Sources: Resident's care plan, resident's kardex, interview with staff and RCM. [585]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee has failed to ensure that resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A resident's SDM requested to urgently speak with the doctor, the request was written in the 'Physician Communication Book'. Later that day, the SDM again requested that they wished to speak to the doctor. Director of Care (DOC) stated the expectation is that staff were to call the doctor when the SDM requested to speak to them urgently.

By not ensuring the SDM had opportunity to fully participate in resident's plan of care, the resident was at risk for delay in changes to treatment.

Sources: Interviews with staff and DOC; and resident's clinical records. [000766]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
A resident's plan of care identified they required a specific level of assistance. One day, the resident was receiving care. A staff went to obtain supplies and another staff initiated care by themselves and performed an action that caused the resident to sustain injuries. DOC acknowledged that the staff did not follow the plan of care for the required level of assistance.

By not following the plan of care the resident sustained injuries.

Sources: Resident clinical records; CI # 2975-000019-24; observation of the resident; and interview with DOC and other staff. [506]

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff who provide direct care to a resident were kept aware of their care requirements and had convenient and immediate access to it.

Rationale and Summary
A resident's kardex did not include information on the resident's level of care to support and/or manage a certain care area. A staff stated the purpose of a resident's kardex was to communicate to staff the resident's needs and there was no information regarding the resident's level of care for a certain care area. A RCM confirmed the kardex did not have the information for direct care staff to access.

Failure to keep staff aware of the resident's care needs increased the risk for the resident to not receive the specific care they required.

Sources: Resident's kardex; resident's care plan; and interview with RCM and staff. [585]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary
A) A resident's Electronic Medication Administration Record (eMAR) displayed a scheduled medication at a specific time to not have documentation on a number of days in a month. Two registered staff members stated the medication was given as scheduled but not documented. An Assistant Director of Care (ADOC) stated the expectation for staff is to document medication administration whether it was refused or given.

By not documenting the administration of medication, the resident was at risk for not receiving the care set out in the plan of care.

Sources: Interviews with ADOC and other staff; and resident's clinical records. [000766]

Rationale and Summary
B) A resident's plan of care stated a device was to be worn at all times. A staff stated the resident required assistance to apply the device.
The resident's monthly Nursing Flow Sheet required staff to check off on each shift that the resident's device was in place and in good working order. The Flow Sheet also directed staff to verbally report any abnormalities to registered staff for documentation. Over 5 consecutive days, there was no documentation to verify that the device was applied for 13 consecutive shifts. Staff reported the resident was compliant with wearing the device but confirmed documentation was not completed as required.

By not documenting the use of the device, the resident was at risk for not receiving the care set out in the plan of care.

Sources: Resident's care plan; Resident's Nursing Flow Sheet; and interview with

staff. [585]

WRITTEN NOTIFICATION: Dietary services and hydration

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 15 (2)
Dietary services and hydration
s. 15 (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied.

The licensee has failed to ensure that the resident was provided with food that was safe.

Rationale and Summary
A resident was not to able to consume a specific food. The resident was served food containing the specific food they were not able to consume. It was noted that the resident did not consume the food; however, a dietary staff confirmed an error was made as they served the food to the resident; therefore unsafe food was provided. At the time of the incident, strategies and interventions were in place inform dietary staff of the resident's needs.

Failure to provide food that was safe for the resident increased risk of experiencing negative side effects from consumption of the specific food.

Sources: Resident's clinical records; and interview with dietary staff. [585]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint that it received concerning the care of a resident in the manner set out in the regulations, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements provided for in the regulations.

Rationale and Summary
Section 109. (1) of Ontario Regulation 246/22 states a complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The home received a compliant which alleged risk of harm to a resident, specifically, that they had been fed a specific food item and developed symptoms from consumption. The following morning, a RCM received the the complaint, and began an investigation and responded to the complainant. The RCM acknowledged that they did not forward the complaint onward.

There was potential for risk of harm to the resident as forwarding written complaints to the Director is a mandatory component in dealing with complaints that allege risk of harm to a resident.

Sources: Complaint regarding the resident; and interview with RCM. [585]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of abuse to a resident by another resident that resulted in harm was immediately reported to the Director.

Rationale and Summary
A) On a day, a resident sustained an injury by another resident. The home did not report the incident of abuse to the Director until the next day. A DOC acknowledged the incident should have been reported immediately to the Director.

Sources: Residents' clinical record; CI #2975-000037-2024 and interview with DOC. [506]

Rationale and Summary
B) CI report was not submitted for an incident that occurred between two residents. A resident reported to a staff member they felt unsafe after receiving death threats from a resident. DOC and staff stated the incident should have been reported to the ministry as it met the definition of verbal abuse.

Sources: Interviews with staff and DOC; and resident's clinical records. [000766]

WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 11.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that the persons who received training under subsection (2) of the act, paragraph 11 received training in the areas mentioned in that section at the intervals as provided for in the regulations.

Rationale and Summary
Fixing Long-Term Care Act (FLCTA) s. 82 (2) identified that all staff in the home are to receive training in the
areas as required.
O. Reg. 246/22 s. 259 (1) 2 identified that training is to be completed for safe and correct use of equipment including positioning aids that are relevant to the staff member's responsibilities.

The home used a specific device for the repositioning of residents. Interviews with several direct care staff identified that they were required to use the equipment; however, they had not received training on the use of the device. Management staff acknowledged that training was not provided to the staff who were required to use the equipment prior to performing their duties.

Failure to provide training on the use of the device resulted in improper use of the equipment.

Sources: Interview with DOC and other staff; and training records. [506]

WRITTEN NOTIFICATION: Compliance with manufacturer's instructions

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary
A resident used a device for care. Two staff went to provide care to the resident. A staff went to obtain supplies and another staff provided care for the resident with the device by themselves and sustained an injury.

The manufacturer's instructions for the device stated under 'Warnings' that:
At least two persons are required for the safe use of this product and prior to use, both persons must read and understand these instructions to ensure patient's safety and prevent injury, do not leave the patient unattended when the device is in use and remove the repositioning slide from under the patient.

The manufacturer's instructions were also not followed during observation of the resident on two separate occasions. The device was observed under the resident when they were not being cared for.

By staff not following manufacturer's instructions on the use of the device, the resident was at risk of further injury.

Sources: Review of resident's clinical record; manufacturers' instructions for the device; interview with DOC and other staff. [506]

WRITTEN NOTIFICATION: Care conference

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure a care conference was held with the interdisciplinary team within six weeks of a resident's admission to discuss the plan

of care and any other matters of importance to the resident and SDM.

Rationale and Summary
ADOC stated the interdisciplinary team that participated in the care conferences included nursing, dietary, social work, pharmacy, occupational therapy, physical therapy, spiritual care, physician and family. A post admission care conference with the interdisciplinary team was not held within six weeks of a resident's admission.

By not having a care conference, the resident was at risk for not having complimentary and cohesive care.

Sources: Interviews with the ADOC; and resident's clinical records. [000766]

WRITTEN NOTIFICATION: General Requirements

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee has 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.

Rationale and Summary
Section 53 of Ontario Regulation 246/22 requires the licensee to ensure that an interdisciplinary falls prevention and management program be developed and

implemented in the home to reduce the incidence of falls and the risk of injury.

As part of the home's falls program, a Post-Fall Follow-up was to be completed after each resident fall.

A resident experienced a fall. A Post-Fall RCM Follow-Up was completed and noted a plan to discuss the implementation of a device with staff and the SDM. The resident's clinical record did not include documentation to suggest whether the device was considered or implemented. RCM reported a decision was made to not implement the device as it would not be an appropriate for the resident; however, confirmed there was no documentation to support the outcome of the reassessment.

Sources: Post-Fall RCM Follow-Up; resident's progress notes; and interview with RCM. [585]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
The resident's plan of care stated, the resident required a specific level of assistance for transferring with a device. The home submitted a CI to the Director stating a staff completed a transfer that was not specified in the resident's plan of care. The resident sustained an injury and had complaints of pain after the incident occurred.

Failure to ensure that staff used safe transferring and positioning techniques when they assisted a resident increased their risk for further injury and harm.

Sources: Resident's plan of care; CI #2975-000039-24; interviews with staff. [506]

WRITTEN NOTIFICATION: Menu Planning

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that planned menu items were offered and available at each meal.

Rationale and Summary
A resident had a disease. They had an individualized menu that had been prepared and approved by the home's Registered Dietitian. On a day, the resident had a planned menu. During meal service, the resident did not receive the planned menu item. The cook confirmed the resident's planned menu item was not available for the meal.

Failure to ensure planned menu items were available at each meal had potential for the resident to receive an unbalanced, inadequate or unsafe meal.

Sources: Supper meal observation; interview with a cook; and resident's individualized menu. [585]

WRITTEN NOTIFICATION: Food Production

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

The licensee has failed to ensure that all menu items were prepared according to the planned menu.

Rationale and Summary
A food item was on the menu for supper. A cook discussed how the menu item was prepared and confirmed they had not followed the standardized recipe for the menu item.

Failure to prepare the menu item according to the planned menu had potential to impact the nutrient composition of the food.

Sources: Dining observation; interview with a cook; and recipe for a food item. [585]

WRITTEN NOTIFICATION: Housekeeping

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, procedures were developed and implemented for cleaning of resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

Rationale and Summary
During the afternoon shift at approximately 1600 hours, the washroom in a resident's room was reportedly found unclean. The unclean condition of the washroom was reportedly brought to the attention of nursing staff.

The Environmental Services Manager (EVSM) reported nursing staff were responsible for cleaning bodily fluids and were then to contact housekeeping to have the area disinfected. According to the EVSM, the home had housekeeping staff available 24 hours a day, seven days a week; however, on that day, no call was made to housekeeping for an additional clean of the washroom. The EVSM confirmed the home's procedure for cleaning of the washroom was not implemented.

Failure to ensure the resident bathroom, including floors and contact surfaces were cleaned appropriately increased the risk of transmission of infection.

Sources: St. Joseph's Villa (SJV) Complaint Form; and interview with the EVSM. [585]

WRITTEN NOTIFICATION: Dealing with complaints

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home that included: (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Rationale and Summary
The home's complaints policy stated "Document concern, resolution, and steps taken to resolve the complaint on the complaint User Defined Assessment (UDA), or "Tell Us How We Are Doing" form. If the complaint is received via email or letter, a User Defined Assessment (UDA) can be completed; however, a copy of the original complaint received should be retained and filed with complaint records."
A complaint was sent to the home by a family member of a resident, alleging the resident was fed a specific food item resulting in symptoms from consumption. A RCM responded to the family member with responses to their concerns.

The home's documented record of complaints was reviewed and did not include the record of the written complaint. The RCM confirmed they did not complete a UDA.

Failure to have a documented record of complaints in the home included each written complaint and all required components as outlined above had potential to create a gap in ensuring complaints are addressed and responded to appropriately.

Sources: Complaints Policy #POL-05 (last revised August 4, 2023); a complaint; and interview with RCM. [585]

COMPLIANCE ORDER CO #001 Plan of care

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The licensee shall perform an audit for three weeks on two residents' behaviours;
2. The audit must include when/if there is a care needs change or care is no longer necessary specifically for the resident's behaviours, the date of the plan of care review, the date of the revision, the changes made, the registered staff who reviewed and revised it; and
3. Maintain a record of the audits for the LTCH inspector to review.

Grounds

The licensee has failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised when the resident's care needs changed or when the care set out in the plan was no longer necessary.

Rationale and Summary

A) A resident exhibited incidents of behaviours. The behaviour was absent on admission; however, presented over a period of time and remained an exhibited behaviour at the time of the inspection.

The resident's plan of care did not show that there had been a reassessment or revision to their plan for the demonstrated behaviour, which was confirmed by a RCM.

Failure to review and revise the plan of care when care needs changed increased the potential of the resident not receiving interventions to manage their behaviour.

Sources: Resident's care plan, resident's progress notes, interview with staff and RCM. [585]

Rationale and Summary

B) An intervention was implemented for a resident soon after admission. The resident was transferred to different unit, and it was assessed that the intervention was no longer needed. The care plan continued to state for the resident to have the intervention. On a day, the resident had the intervention on evenings but not on nights. ADOC stated the intervention was to be discontinued once the resident was transferred. The care plan was not revised to reflect the change.

Failure to review and revise the plan of care when the care set out in the plan was no longer necessary increased the risk of the resident not receiving the appropriate care.

Sources: Interview with ADOC; and resident's clinical records. [000766]

This order must be complied with by June 25, 2024

COMPLIANCE ORDER CO #002 Duty to protect

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The licensee shall ensure a resident's safety plan in their care plan is updated and is followed by all staff on the unit;
2. Perform daily audits on every shift for two weeks on resident's safety plan to ensure that it is in place;
3. Document the audits, including any identified discrepancies and corrective actions taken made based on discrepancies; and
4. Maintain a record of the audits for the LTCH inspector to review.

Grounds

The licensee has failed to ensure that the residents were protected from abuse by another resident that resulted in harm.

Rationale and Summary

O. Reg. 246/22 s. 2 (1) (b) defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences".

O. Reg. 246/22 s. 2 (1) (c) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

A) Two residents were known to have a history of altercations, and an intervention was put in place for one of the residents to prevent further altercations between the two residents. A resident entered another resident's room and was verbally threatening the resident and then approached them with an object causing injury to

the other resident. The resident was discharged from the home to prevent risk of harm to residents.

Interview with a staff member who responded to the incident acknowledged that the intervention was not on at the time of the incident. DOC acknowledged that this incident met the definition of verbal and physical abuse.

By not protecting a resident from verbal and physical abuse, the resident sustained a physical injury and voiced being fearful for their safety.

Sources: Interviews with the resident, DOC, and staff; and residents' clinical records. [000766]

Rationale and Summary

B) Two residents were known to have a history of altercations. The residents were in close proximity to each other when one of residents caused injury the other resident. Interview with a staff who responded to the incident and DOC acknowledged that this incident met the definition physical abuse. The resident was transferred to another unit to prevent further harm to the other resident.

By not protecting the resident from physical abuse, the resident sustained an injury.

Sources: Interviews with DOC, and other staff; and residents' clinical records. [000766]

This order must be complied with by June 18, 2024

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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