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

Original Public Report

Report Issue Date: August 23, 2024
Inspection Number: 2024-1458-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 26, 29 - 31, 2024 and August 1 -2, 6 - 9, 12-16, 19 and 20, 2024

The following intake(s) were inspected:

- Intake: #00116712 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)
- Intake: #00116713 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (10) (b)
- Intake: #00113019 - Critical incident related to an unexpected death of resident.
- Intake: #00117435 - Critical incident related to falls prevention and management.
- Intake: #00117758 - Critical incident related to prevention of abuse and neglect.
- Intake: #00121376 – Critical incident related to medication management.
- Intake: #00118583 - Complaint related to plan of care, skin and wound care, prevention of abuse and neglect, continence care and bowel management,

food, nutrition and hydration, resident care and support services and medication management.

The following intakes were completed in this inspection:

- Intake: #00113778 – Critical incident related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1458-0002 related to FLTCA, 2021, s. 6 (10) (b)

Order #002 from Inspection #2024-1458-0002 related to FLTCA, 2021, s. 24 (1)

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident was protected from abuse.

Rationale and Summary
A resident hit another resident on their chest. The next day a bruise was identified on the affected resident and a nurse attributed the bruise to the incident the previous day. The plan of care for the resident who hit the other resident, included a focus statement that the resident had a history related to ongoing physical responsive behaviours, including hitting others. Staff confirmed this. Failure to ensure that a resident was protected from physical abuse by another resident resulted in actual harm.

Sources: Residents' clinical records, interviews with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that an incident of abuse was immediately investigated.

Rationale and Summary
A resident hit another resident and the incident was reported to a nurse but an investigation was not initiated until the following day. This was confirmed by staff. By not beginning an immediate investigation other residents were potentially at risk of injury.

Sources: Residents' clinical records, interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 was immediately reported to the Director.

Rationale and Summary
A resident hit another resident and the next day a bruise was identified on the affected resident. A nurse attributed the bruise to the incident the previous day. The incident was not reported to The Ministry of Long-Term Care after hours line until the day after it occurred and staff confirmed this.

Sources: Critical incident report and after hours report, residents' clinical records and interviews with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1. Complete an Interdisciplinary assessment related to positioning and chair alarm for resident the identified resident.

2. Perform a daily audit for three weeks for the identified resident on the use of the chair alarm and resident safety while in the wheelchair and document the audits including the person who completed the audit, the date and time that the audit was

completed and what interventions are in place.

3. Implement an audit system for chair alarms.

4. Create a process for how staff will familiarize themselves with the identified resident's plan of care i.e., conducting education to Nursing staff re: door alarm and resident's weight checks.

5. Create a process for auditing the identified resident's door alarm monthly to ensure the battery charge is sufficient.

6. Create a process to ensure that monthly weights are completed for the identified resident at a scheduled time each month and provide education to nursing staff.

Grounds
The licensee has failed to ensure that a resident's safety alarm was working as specified in the plan.

Rationale and Summary
A. During resident's room observation, the door alarm did not sound when inspector opened the door to enter and exit the room. Inspector confirmed with staff that the alarm was not working. The door alarm is attached to the resident's door and sounds when the door opens and closes to alert staff to check on the resident. The plan of care states that "door alarm in place and ensure working to alert staff that resident exiting room or resident entering others room".

During an interview, a PSW stated that the door alarm is on the door but had not been working since the day before and may need a battery.

The home not ensuring a working alarm puts the resident's safety at risk.

Sources: observation, Plan of Care, Interview with staff.

The licensee has failed to ensure that a resident was weighed monthly as specified in the plan of care.

Rationale and Summary
B. During a record review there was no weight recorded for a month and no progress note to indicate the reason for the documentation not being completed.

During an interview with the ADOC, they acknowledged that the weights were not completed for that month and there were no progress notes to indicate why it was not completed.

By not completing the monthly weights, the resident's weight loss could not be tracked to put immediate interventions in place.

Sources: PCC weight record, Plan of care, Interview with ADOC.

The licensee has failed to ensure that a resident's chair alarm was in place as specified in the plan of care.

Rationale and Summary
C. It was documented in a resident's plan of care that a chair alarm was to be used when the resident was in their wheelchair. The resident was observed by the inspector, sitting in their wheelchair in the lounge and there was no chair alarm in place. This was confirmed by staff. Director of Care (DOC) confirmed that the chair alarm is in the plan of care and therefore was expected to be in place.

Sources: Residents' clinical records. interviews with staff and an observation.

This order must be complied with by November 8, 2024

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.