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

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Original Public Report

Report Issue Date: October 31, 2024

Inspection Number: 2024-1458-0004

Inspection Type:
Complaint
Critical Incident

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 dates: October 17, 18, 20, 21, 22, 24, 25, and 28, 2024.

The following intakes were inspected:

- Intake: #00117414 - for a Critical Incident report related to duty to protect.
- Intake: #00122385 - for a Critical Incident report related to duty to protect.
- Intake: #00123778 - for a Critical Incident report related to duty to protect.
- Intake: #00123778 - for a Critical Incident report related to duty to protect.
- Intake: #00126612 - for a complaint related to continence care and bowel management, plan of care, skin and wound care and nutritional care and hydration program.
- Intake: #00127631 - for a Critical Incident report related to falls prevention and management.
- Intake: #00128524 - for a Critical Incident report related to an injury which resulted in transfer to hospital and a significant change in condition.

The following intakes were completed in this inspection:

- Intake: #00123242 - for a Critical Incident report related to falls prevention and management.

- Intake: #00123660 - for a Critical Incident report related to falls prevention and management.

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

Continence Care
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 plan of care was provided to a resident as

specified in the plan.

Rationale and Summary
The plan of care for a resident identified they required a device in place for safety and directed staff to ensure the device was on and worked properly.
The device was observed off for a period of 30 minutes, when the resident was not in their room.
Staff confirmed that in order for the device to be on a condition was to be met. Once identified the condition was met and the device was on.
There was no impact or risk identified during the identified time period.

Sources: Review of plan of care for a resident, observations and interview with staff.

Date Remedy Implemented: October 20, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessments of the resident so that their assessments were integrated, were consistent with and complemented each other.

Rationale and Summary
a. A Falls Risk Assessment Tool (FRAT) completed for a resident identified they were at a specified risk of falls.
Following the FRAT assessment the resident sustained a fall. The Fall Incident / Post Fall note completed identified the resident's current FRAT score was at a different risk level, than identified on the most recent FRAT.
The Fall Incident / Post Fall note was not consistent with the FRAT assessment completed.

b. A Fall Incident / Post Fall note identified that a resident was not on the falling leaf program, nor was the program initiated.
The following day the resident sustained a fall. The Fall Incident / Post Fall note identified the resident was on the falling leaf program; however, the program was not an intervention in the care plan, nor was a leaf on the resident's bedroom door or mobility device. Following a review of the record staff identified the resident did not meet the criteria for the falling leaf program.

Sources: Observations of a resident, review of FRAT, Fall Incidents / Post Fall notes and care plan for the resident and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 staff provided care as specified in the plan for a resident related to their nutritional needs.

Rationale and Summary
A resident's plan of care identified if they refused their meal, staff were to provide them with specific food items.
When observed the resident did not eat their meal; however, the specific food items were not offered / provided until a request was made by a visitor.
Failure to provide the resident with the nutritional intervention when they did not eat their meal, placed them at an increased nutritional risk.

Sources: Dinner observation, kardex and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 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 and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary
The plan of care for a resident included their preference for specific caregivers only. Additionally, staff confirmed there was a sign posted which noted their caregiver preference.

The home identified that a staff member, who was not a preferred caregiver, provided care to the resident.
The staff verified they were not aware of the contents of the resident's plan of care specific to their preference of caregivers.
By the staff not being aware of the contents of the plan of care the resident received care not consistent with their preferences.

Sources: Resident's clinical record; investigation notes; interview with resident; and interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #005 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
There was a witnessed incident involving two residents where one resident sustained a superficial injury.
Staff documentation identified that the injured resident displayed verbal and non verbal cues after the incident.
Failure to ensure that a resident was protected from abuse by a co-resident, resulted in harm.

Sources: Review of a Critical Incident report, review of clinical health records and

staff interviews.

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act.

The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have a pain management program, that the program was in compliance with all applicable requirements under the Act.

O. Reg. 246/22, s. 53 (1) 4 included that the licensee was to have an interdisciplinary pain management program to identify pain in residents and manage pain.
O. Reg. 246/22, s. 57 (2) included that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rational and Summary
The home's Pain Program did not include that when a resident's pain was not relieved by initial interventions, the resident was to be assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Failure to include the requirement to assess a resident with a clinically appropriate assessment instrument when initial interventions were not successful in managing pain had the potential for additional measures to not be tried or implemented.

Sources: Review of Pain Program and interviews with staff.

WRITTEN NOTIFICATION: General requirements

NC #007 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
a. A resident required staff assistance.
To prevent alterations in skin integrity, directions for staff included to monitor the resident's skin condition using flow sheets. Review of the documentation did not include any of the resident's skin condition for 15 days.
Staff confirmed there should be documentation each shift and a report of any new or worsening alterations in skin integrity.
Failure to document the resident's skin condition placed the the resident at risk by limiting the staffs ability to identify new or worsening areas of altered skin integrity.

Sources: Residents records, interview with staff, and review of skin and wound program policy.

Rationale and Summary
b. A resident required nutritional interventions.
Review of the food and fluid intake records for a period of two months, included 13 days where the resident's meal or snack intake was not documented, as required in the home's policy.
Staff confirmed that dietary flowsheets should be initiated and completed each shift.

Sources: Food and fluid records for a resident, the home's policy, interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, they were assessed with a clinically appropriate assessment instrument specifically designed for that purpose.

Rational and Summary
A resident was on routine and as needed analgesics for indicators of pain.

The electronic Medication Administration Record (eMAR) and pain assessments completed identified occasions where initial pharmacological interventions were not successful to relieve the resident's pain; however, they were not assessed with a clinically appropriate assessment instrument specifically designed for pain.
Failure to assess the resident had the potential for unmet needs related to pain management.

Sources: A review of progress notes, eMAR, and pain assessment for a resident and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that no drug was administered to a resident unless the drug was prescribed for a resident.

Rationale and Summary
a. A resident had an order for a medication to manage behaviours. After a discussion, it was decided to change the dosage of the medication as it might contribute to the resident's behaviours. The Physician wrote an order to decrease the medication.
The Physician completed a medication review the following month and noted that the previous order was not processed.

Failure to reduce the medication dosage might have contributed to further responsive behaviours.

Sources: A resident's clinical record and interview with staff.

Rationale and Summary

b. A resident had orders for routine and as needed analgesic.
The care plan included to assess for pain, ensure comfort and look for non-verbal signs including behaviours.
Progress notes and electronic Medication Administration Records (eMAR) included occasions where the resident verbalized pain or presented with behaviours and as needed analgesic was not given as prescribed.
Failure to administer the as needed medication as prescribed had the potential for the resident to experience pain.

Sources: Review of progress notes, eMAR, and plan of care for a resident and interviews with staff.