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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Public Report

Report Issue Date: December 20, 2024
Inspection Number: 2024-1458-0005
Inspection Type: Proactive Compliance Inspection
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): December 9-11, 13, 16-17, 2024

The following intake(s) were inspected:

- Intake: #00133830 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

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: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that a window, which opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Rationale and Summary
The window in a resident bedroom could be opened more than 15 centimetres. The next day, the window stops were replaced, and the window was restricted to no more than 15 centimeters.

Sources: Observations of a resident room and staff interviews.

Date Remedy Implemented: December 13, 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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident and on the needs and preferences of that resident.

Rationale and Summary
A resident had a personal assistance services device (PASD) in place as per their preference. The resident's plan of care did not include an assessment related to the use of the device.
Failure to ensure that the plan of care was based on an assessment of the preferences of the resident had the potential for the staff to be unaware of the resident's wishes.

Sources: Observations; resident and staff interviews.

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.

A) The licensee has failed to ensure that a resident was provided with an eating aid,

as per their plan of care.

Rationale and Summary
A resident's written plan of care indicated that they required an eating aid at meals. The lunch meal was observed, and the resident was not provided with the eating aid.

Sources: Dining observation; a resident's clinical record; staff interviews.

B) The licensee has failed to ensure that a resident was provided with a nutrition intervention, as per their plan of care.

Rationale and Summary
A resident's plan of care indicated that they required a nutritional intervention with meals to support intake and meet nutritional needs. During an observation, they were not provided with the intervention.

There was potential for inadequate nutritional intake when the resident was not provided with their nutritional intervention as ordered.

Sources: Dining observation; a resident's clinical record; staff interviews.

WRITTEN NOTIFICATION: Doors in a Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors

leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that all doors which led to the outside of the home were kept closed and locked.

Rationale and Summary
A door which led to the outside was observed to be open and the area was unsupervised.
Following a discussion with staff the door was observed supervised and staff confirmed that the door remained supervised until it was repaired.
Failure to ensure that doors which led to the outside of the home were kept supervised when not closed and locked had the potential for resident elopement.

Sources: Observations of the door and staff interviews.

WRITTEN NOTIFICATION: Doors in a Home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors which led to non-residential areas were equipped with a lock to restrict unsupervised access to those areas by

residents, and those doors were kept closed and locked when not supervised by staff.

Rationale and Summary
A number of non-residential areas on a floor of the home were not secured or supervised by staff.
The home reported plans to install locks on each door and confirmed that the areas were not residential areas.
There was a risk that residents could access the non-residential areas.

Sources: Observations; staff interviews.

WRITTEN NOTIFICATION: Communication and Response System

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(e) is available in every area accessible by residents;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area which was accessible by residents.

Rationale and Summary
Areas on one floor of the home, which were accessible to residents, were not equipped with a resident-staff communication and response system.
Failure to have a resident-staff communication and response system in areas which were accessible to residents had the potential for residents to not be able to alert

staff should they require assistance.

Sources: Observations and staff interviews.

WRITTEN NOTIFICATION: Communication and Response System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(f) clearly indicates when activated where the signal is coming from; and

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal came from.

Rationale and Summary
A resident reported that their call bell did not work. When the communication and response system was activated in the resident's room the outside door dome light did not light up. A Personal Support Worker (PSW) confirmed that the communication and response system did not clearly indicate where the signal came from when activated for the resident's room as well as for two other rooms on the resident home area. They noted that if there was no light on when a bell rang they checked the three rooms to determine who rang the bell, as the screen previously used to display which call bells were activated no longer worked.
There was a potential delay in staff response to activated communication and response system bells for the three residents when the system did not clearly indicate where the signal came from.

Sources: Observations; interview with a resident, PSW and other staff.

WRITTEN NOTIFICATION: Air Temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
Building Automated System (BAS) air temperature monitoring logs, identified that areas of the home were not consistently maintained at a minimum temperature of 22 degrees Celsius.
A staff member confirmed that the heating and cooling system fluctuated due to several factors during the identified time periods and that with interventions, when temperatures were below 22 degrees Celsius, typically it took the system 24 – 48 hours to settle to the desired results.
There was a risk that residents were not comfortable in the home when the temperature was not maintained at 22 degrees Celsius.

Sources: Review of Air Temperature Monitoring Logs and staff interviews.

WRITTEN NOTIFICATION: General Requirements

NC #009 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.

A) The licensee has failed to ensure that any actions taken with respect to a resident under the nursing services program, as required in FLTCA s. 11 (1) were documented.

Rationale and Summary
A resident expressed concerns that they were not bathed as per their preferred method. Staff on the unit indicated the resident was bathed as per their preference once a week, but not on their other scheduled bath day. The Resident Care Manager (RCM) indicated that they discussed this with the resident, but the resident did not recall the conversation.

There was no documentation in the resident's plan of care regarding the discussion with the RCM.

Sources: A resident's clinical record; staff interviews.

B) The licensee has failed to ensure that any actions taken with respect to a resident under the required program of skin and wound care, including interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident had alterations in skin integrity and was to be turned and repositioned every two hours, as set out in their plan of care.
The resident reported they were not repositioned as scheduled.
A review of the progress notes and flow sheets did not include the resident's response to the intervention of repositioning.

Sources: A resident's clinical record; staff interviews.

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure that residents were served course by course.

Rationale and Summary
During an observation of meal service, several residents were served their dessert, prior to being finished their main course.
There was potential for inadequate nutritional intake when the residents were not served course by course.

Sources: Dining observations; staff interviews.

WRITTEN NOTIFICATION: Hazardous Substances

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

In accordance with O. Reg. 246/22, s. 12 (1) 3, all doors which lead to non-residential areas were to be equipped with locks which restricted unsupervised access to those areas by residents, and those doors kept closed and locked when not supervised by staff.

Rationale and Summary
A) Two clean utility room doors were found unlocked. On entry to the rooms, there were hazardous substances on the counters.
A staff member acknowledged that the doors were to be closed and locked when staff were not present.
There was a potential risk of chemical exposure to residents when hazardous substances were accessible through unlocked doors.

Sources: Observations; staff interviews.

B) The soiled utility room and tub room on a resident home area were found unlocked and unattended. The rooms contained both opened and sealed bottles of a hazardous substance, and unlabeled bottles of another substance.
Staff confirmed the doors should be locked due to the substances and closed them immediately.
There was a potential risk of chemical exposure to residents when hazardous substances were accessible through unlocked doors.

Sources: Observations; staff interviews

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, with a revised date of September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal of PPE.

A resident had a sign on their door which identified they were on additional precautions and required PPE to be worn for personal care. Two Personal Support Workers (PSWs) were observed in the resident's room providing care and one of the PSWs was not wearing any PPE. Once care was completed, the other PSW left the room and doffed their PPE and then proceeded to walk away without completing hand hygiene.

A staff member acknowledged the PSWs were providing personal care to the resident and did not wear the required PPE and the staff member should have completed hand hygiene at point of care.
Failure to use PPE and complete hand hygiene posed a risk of spreading infection to

other residents.

Sources: Observations; staff interviews.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that every verbal complaint made to a staff member concerning the care of resident #009 was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation was commenced immediately.

Rationale and Summary
Progress notes included that a resident voiced concerns on two occasions regarding the care they received.
There was no investigations into the concerns nor a response provided to the resident related to their complaints.

Failure to investigate and follow up on concerns had the potential for a reoccurrence of issues and or resident dissatisfaction.

Sources: Review of the clinical health record of a resident; the home's complaints process and staff interviews.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), the prescriber of the drug and the resident's attending physician.

Rationale and Summary
Review of the home's medication incidents for a period of three months identified that not all incidents were reported to the resident or the resident's SDM and the

resident's attending physician. A staff member acknowledged that this was not completed for all medication incidents. Failure to notify the resident or resident's SDM or physician of the possible adverse drug reaction may have prevented increased monitoring or identification of potential side effects.

Sources: Review of medication incidents; staff interview.

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