



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prevue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection August 5, 2010	Inspection No/ d'inspection 2010_146_2975_04Aug122813	Type of Inspection/Genre d'inspection Critical incident C566-000025-10 H - 00334
Licensee/Titulaire St Joseph Health System, 56 Governor's Road, Dundas, On L9H 5G7		
Long-Term Care Home/Foyer de soins de longue durée St Joseph Villa, 56 Governor's Road, Dundas, L9H 5G7		
Name of Inspector(s)/Nom de l'inspecteur(s) Barbara Naykalyk-Hunt, LTC Homes Inspector #146		
Inspection Summary/Sommaire d'inspection		
The purpose of this inspection was to conduct a critical incident inspection. During the course of the inspection, the inspector spoke with ; Acting DOC, nursing manager, administrative assistant During the course of the inspection, the inspector(s): conducted a health record review and a telephone interview with the Acting DOC The following Inspection Protocols were used during this inspection: pain ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 2 WN 1 VPC		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régleur envoyé
CO – Compliance Order/Ordre de conformité
WAO – Work and Activity Order/Ordre: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s. 107. 4

A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

Findings:

1. The resident was sent to hospital in July 2010. On the following day, the home was notified that an x-ray showed an injury. A CIS was not submitted to the MOHLTC until 14 days later.

Inspector ID #: 146

Additional Required Actions:.

WN #2: The Licensee has failed to comply with: O. Reg. 79/10, s. 24(9)

The licensee shall ensure that the resident is re-assessed and the care plan is reviewed and revised when
(a) the resident's care needs change.

Findings:

1. The resident's progress notes reveal that:
 Day 1 - resident cries out in pain when staff dress the resident (source of pain not assessed)
 Day 10 - charted again the resident cries out in pain when dressed. Action suggested to give analgesic prior to dressing but source of pain not addressed
 Day 13 - resident yelling out +++ and aggressive with staff
 Day 18 - resident complaining of pain - analgesic given - source of pain not assessed

Day 22 – in afternoon resident groaning and stated in pain - analgesic given - source of pain not assessed
 Day 22 - resident moaning all through supper
 Day 23 - resident groaning
 Day 26 - resident "looking very uncomfortable" in wheelchair, sliding out of chair, calling out stopped after resident was put back to bed
 Day 27 - stayed in bed and seemed comfortable
 Day 30 - yelling frequently and stopped when put to bed
 Day 31 - resident disruptive when sitting up in dining room
 Day 32 - "resident groaning" - still no evidence in notes that source of pain was assessed, analgesic given sent to hospital for urological problem where an injury was diagnosed

Inspector ID #: 146

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 for the re- assessment of changing needs, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

**Signature of Health System Accountability and Performance Division
 representative/Signature du (de la) représentant(e) de la Division de la
 responsabilisation et de la performance du système de santé.**

Barbara Nayabzif-Hunt
Dec 6/10

Title:

Date:

Date of Report (If different from date(s) of inspection).