Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 28, 2021	2021_739694_0020	004868-21, 004900-21, 006565-21, 009674-21, 010555-21	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 Hamilton ON L8N 4A6

Long-Term Care Home/Foyer de soins de longue durée

St. Joseph's Health Centre, Guelph
100 Westmount Road Guelph ON N1H 5H8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 23, 24, July 5, 6, 7, 8, 9, 12, and 13, 2021.

Inspector Brittany Nielsen, #705769, was present at the inspection on July 5, 6, 7, 8, 9, 12 and 13, 2021.

The following intakes were inspected during this complaint inspection:
Log #006565-21, Log #004900-21, Log #009674-21, and Log #010555-21 related to fall prevention;
and Log #004868-21, related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), maintenance staff, family members and residents.

The inspectors also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures, and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21. (1).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

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

Multiple temperature readings of the home were below 22 degrees Celsius when air temperature was tested by the inspector during the inspection. The maintenance staff showed the inspector the minimum temperature was set at 22 degrees Celsius or higher and the building automation system (BAS) would change colour on the computer screen indicating if the temperature was above or below the set temperature. A number of temperatures on the screen at the time were three or four degrees lower than 22 degrees Celsius, however the maintenance staff were not alerted of this unless they were looking directly at the BAS screen.

Maintenance staff were notified of temperatures lower than 22 degrees Celsius when the inspector tested them, however the home's temperature remained below 22 degrees Celsius throughout the inspection. The inspectors observed residents wearing blankets during the course of the inspection.

Sources: observations of the home's BAS and inspector tested air temperatures, interviews with maintenance staff and DOC #101. [s. 21.] [s. 21. (1)]

2. The licensee failed to ensure that the air temperature was measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation 79/10 included additional amendments related to cooling requirements and air temperatures in the LTC home.

The home was required to at a minimum measure and document in writing the air temperatures in the following areas of the home: two resident bedrooms in different parts of the home, and one resident common area on every floor of the home. These temperatures were required to be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Maintenance staff stated the home's air temperatures were recorded by a building automation system (BAS) that was in their office. They said the system did not save the temperatures recorded and that maintenance staff did not document the temperatures recorded in writing.

By not documenting the temperatures recoded by the BAS in writing, the home may be unable to detect when there is a trend related to a temperature concern. This put residents at risk for a temperature related illness.

Sources: observations of the home's BAS and inspector tested air temperatures, interviews with maintenance staff and DOC #101. [s. 21. (3)]

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 to ensure that the air temperature is maintained at a minimum of 22 degree Celsius and measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements are kept, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was immediately notified when a resident went missing from the home and returned to the facility with injuries.

A resident was identified to be missing from the home. The resident was having pain when they returned to the home on the same date. A critical incident (CI) report was not immediately submitted to the Director .

By not reporting the incident to the Director immediately, the Director was unable to respond to the incident immediately.

Sources: CIS report, resident’s progress notes [s. 107. (1)]

2. The licensee has failed to ensure that when two residents had a fall and were transferred to hospital for further medical assessment and treatment of an injury that resulted in a significant change in the resident’s health condition, the Director was notified within three business days.

A) A resident had an unwitnessed fall on a specific date and was transferred to hospital on the same day. The resident returned to the home, with a diagnosis of an injury that required on going treatment and intervention. A CI report was submitted to the Director six days later.

Sources: CI report, resident’s Progress notes

B) Another resident had an unwitnessed fall and went to hospital for further assessment. The resident experienced a change in their mobility, was now wheelchair bound, and an order for pain medication was prescribed due to increased pain. Physiotherapy assessed the resident ten days after the fall and recommended further assessment, which identified an injury. The home did not submit a CI to the Director as the home was not aware of the extent of the injuries the resident had sustained.

By not reporting the resident's falls with injuries to the Director as required, the Director may have been unable to respond to the incidents in a timely manner.

Sources: observations of the resident, resident’s Progress notes, resident's electronic Medication administration records (eMAR). [s. 107. (3.1)]

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 to ensure the Director is immediately notified when a resident is missing and returned to the facility with injuries and ensure that when a resident has a fall and is transferred to hospital for further medical assessment and treatment of an injury that resulted in a significant change in the resident's health condition, the Director is notified within three business days, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care related to bed mobility was provided to a resident as specified in their plan of care.

A resident's plan of care and staff stated they required extensive assistance from two staff for repositioning and it directed staff to reposition them every two hours. Documentation showed that staff did not reposition the resident as per their plan of care and that staff documented that repositioning every two hours was not completed for a period of time. The resident then developed two new areas of altered skin.

Not repositioning the resident as per their plan of care, may have contributed to them developing altered skin integrity.

Sources: Observations of the resident, Point of care (POC) documentation survey, resident's skin assessments, resident’s care plan and PSW interview. [s. 6. (7)]

2. The licensee failed to ensure that when resident’s care needs changed, related to transfer and mobility, their plan of care was reviewed and revised.

A resident was observed sitting on a mechanical lift sling during the inspection. The logo at the resident’s bedside indicated they transferred independently and with supervision. Their care plan stated one - two person physical assist for transferring. A PSW said the resident was no longer able to weight bear and required two staff and a mechanical lift for all transfers.

Not revising the resident's plan of care when their care needs changed could have resulted in staff transferring the resident incorrectly. This put the resident at potential risk from harm.

Sources: observations of the resident, resident’s clinical record, PSW interview. [s. 6. (10) (b)]

Issued on this 9th day of August, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.