Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Oct 30, 2014;	2014_201167_0021 (A1)	H-001078-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
99 Wayne Gretzky Parkway, BRANTFORD, ON, N3S-6T6

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

ST JOSEPH'S LIFECARE CENTRE
99 WAYNE GRETZKY PARKWAY, BRANTFORD, ON, N3S-6T6

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

MARILYN TONE (167) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's orders. The Director's review was completed on October 21, 2014. Order CO #001 was rescinded to reflect the Director's review.

Issued on this 30 day of October 2014 (A1)

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

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

MARILYN TONE (167) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 12, 13, 14, 15, 18, 19, 20, 21, 2014.

The following inspections were completed simultaneously with this Resident Quality Inspection and any areas of non compliance related to these inspections will be included in this report.

Complaint Inspection: H-001082-14

Critical Incident Inspections: H-000908-13, H-001036-14, H-000447-14, H-000510-14, H-000516-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Programs and Support Services (DPSS), Resident Care Coordinator (RCC), Registered Dietitian (RD), Nutrition Services Manager (NSM), Resident Assessment Instrument Coordinator (RAI Coordinator), Recreation Therapist, identified residents and family members, registered staff, personal support workers (PSWs), dietary aides, restorative coaches, laundry staff, and a physio assistant.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care, meal service and medication administration, conducted a review of the health records for identified residents, relevant policies and procedures, investigation notes completed by the home, minutes of meetings and menus, production sheets and recipes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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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	Legendé 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 LTCHA, 2007, s. 3. Residents' Bill of Rights

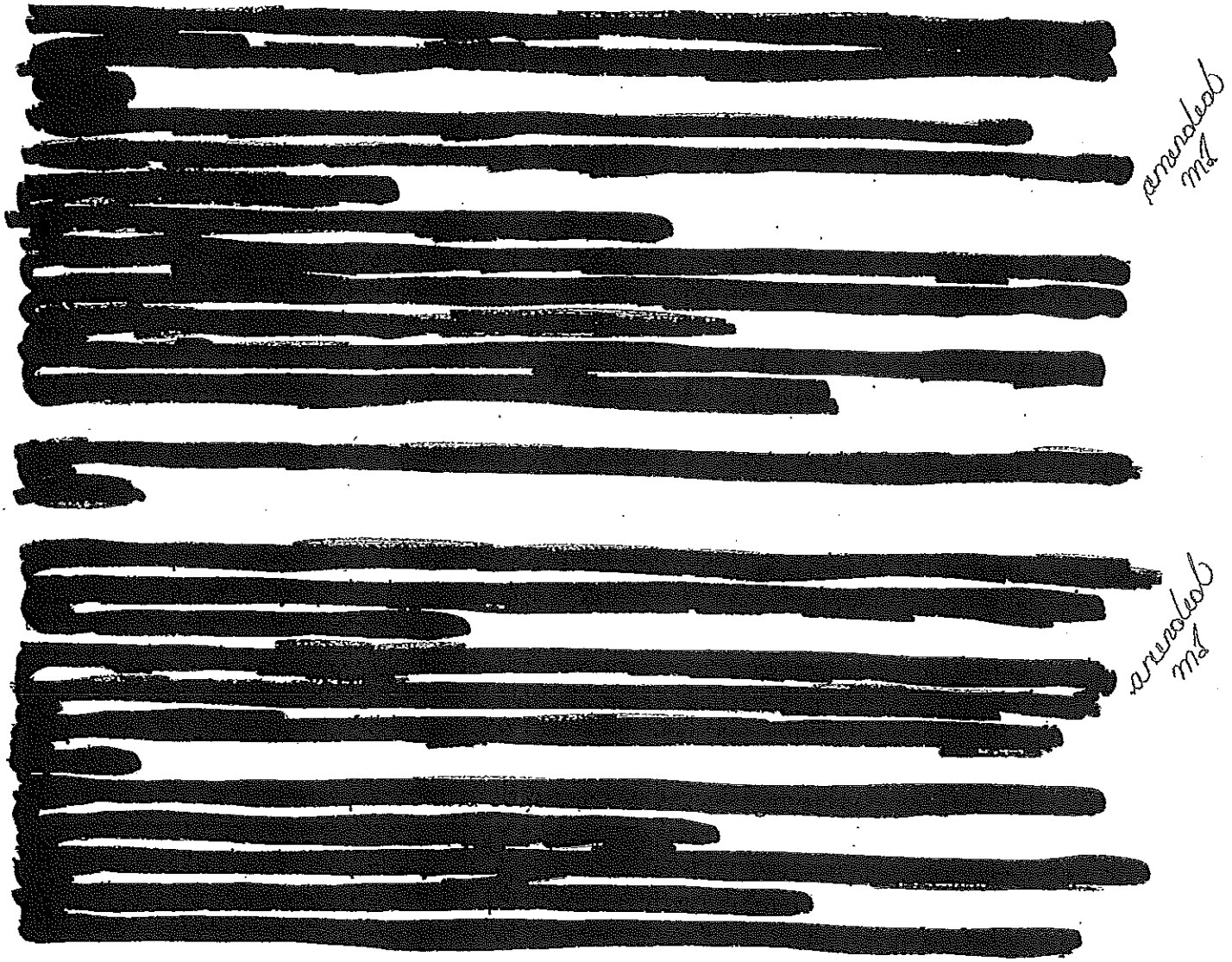
Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

[redacted]

amended MT



1. The licensee did not ensure that resident # 202 was protected from abuse by a co-resident.

On an identified date in 2013, resident #202 was struck by co-resident #201 and pushed to the floor resulting in an injury to resident #002. The physician assessed the resident and ordered an X-ray that was noted to be negative for any fracture. Resident #202 was not protected from abuse by a co-resident. [s. 3. (1) 2.].

Additional Required Actions: V, PC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8 s. 152(2) the licensee is hereby required to prepare a written plan of correction for achieving compliance to ensure that resident # 002's right to be protected from abuse is fully respected and promoted, to be implemented voluntarily m.l.

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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 did not ensure that staff and others involved in the different aspects of

care of the resident collaborated with each other a) in the assessment of the resident so their assessments were integrated and were consistent with and complemented each other.

A) In June 2014, it was noted in the physician's orders that the four point auto seat belt was discontinued for resident #008.
i) Resident #008 was observed to be using a full table top and a four point auto seat belt when in their wheelchair on August 14 and 15, 2014 by Inspector #167.
ii) The document that the home refers to as the care plan for the resident indicated that the resident was to use the full table top and the four point auto seat belt in the wheelchair to increase the resident's ability to participate in activities of daily living. The staff interviewed confirmed that the table top and seat belt were considered to be Personal Assistive Service Devices (PASDs).
iii) Registered staff and personal support worker staff interviewed confirmed that the resident was to use a full table top and a four point auto seat belt when up in their wheelchair.
iv) None of the staff interviewed were aware that the physician had discontinued the use of the seat belt as there had not been collaboration in the assessment. [s. 6. (4) (a)]

2. The licensee did not ensure that the care set out in the plan of care was provided to the residents as specified in their plans of care.

A) Resident #400's plan of care, including the diet list and the document the home refers to as the care plan, stated that the resident was to receive a restricted diabetic diet. During lunch meal service observation on August 14, 2014, the resident received a regular diet.

B) Resident #401's plan of care, including the diet list and the documented care plan, stated that the resident was to receive small portions at meals due to their diagnosis. During lunch meal service observation on August 14, 2014, the resident received the regular entrée portion of a full cheese and onion sandwich rather than the small portion diet serving of one half of a sandwich.

C) Resident #402's plan of care, including the diet list and the documented care plan, stated that the resident was to receive an energy-controlled diet as their Body Mass Index (BMI) was above their goal weight range. During lunch meal observation on August 14, 2014, the resident received a regular entrée portion of four chicken nuggets rather than the restricted-energy diet serving a three ounce chicken breast.

D) Resident #405's plan of care, including the diet list and the documented care plan, stated that the resident was to receive an energy-controlled diet to achieve gradual weight loss. During dinner meal observation on August 15, 2014, the resident received a regular entrée portion of battered Pollock and french fries rather than the restricted-energy diet portion of unbreaded baked Pollock and mashed potatoes.

E) Resident #404's documented care plan stated that the resident was to receive chocolate milk at meals to increase their caloric intake. The resident has experienced significant weight loss over the last quarter. During dinner meal observation on August 14, 2014, the resident was not offered and did not receive chocolate milk. This intervention was not listed on the home's master diet list located in the servery. [s. 6. (7)]

3. The licensee did not ensure that staff and others who provide direct care to the resident had convenient and immediate access to the most current plans of care for residents #008 and #004.

A) On August 14 and 15, 2014, Resident #008 was observed to be using a full table top and a four point auto seat belt in their wheelchair.
i) Registered staff, personal support staff and the two Restorative Care Coaches interviewed confirmed that the resident was to be using a full table top and a four point auto seat belt in their wheelchair.
ii) A review of the Kardex, that was confirmed to be the document that the home uses to direct care for residents and is used by the personal support worker staff, did not include identification of the full table top or the four point auto seat belt that was to be used by resident #008 in their wheelchair.
iii) The care plan that was found in the electronic documentation system did include the use of these devices for the resident, but was not accessible to direct care for the personal support worker staff caring for the resident.(167)

B) Resident #004 was observed on August 12, 2014 to be using a tilt wheelchair and a four point seat belt. An interview with a registered staff member and two Restorative Coaches confirmed that the resident required the use of both the tilt wheelchair and the four point seat belt. The most current electronic care plan for the resident included these interventions, however, the Kardex that the home used to direct the care provided by PSWs to residents, did not include the use of the tilt wheelchair and the four point seat belt. This was confirmed by the Restorative Coaches. (506) [s. 6. (8)]

4. The licensee did not ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan was no longer necessary.

A) Resident #201 had a physical and verbal altercation with a co-resident in May 2013 which caused injury to the co-resident. A review of the health record indicated that the resident's plan of care was not reviewed and revised to include these responsive behaviours until January 2014. The Resident Care Coordinator confirmed that this information should have been added to the plan of care before January 2014. [s. 6. (10) (b)]

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 residents receive care as per their plans of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument after residents #010 and #001 sustained falls.

The home's policy related to [Fall Prevention and Management - 5-CP-100 dated as reviewed April 2013] directed staff to complete the Falls Risk Assessment after each fall.

A) On an identified date in August 2014, resident #010 sustained a fall.
i) During a review of the health care record for the resident, it was noted that there was no post falls assessment completed related to the identified fall.
ii) The Director of Care confirmed that no post falls assessment was completed for resident #010 after they sustained the identified fall in August 2014.(167)

B) On an identified date in May 2014, resident #001 sustained a fall with injury. An interview with the DOC on August 18, 2014 and a a review of documentation confirmed that the resident did not receive a post fall assessment using a clinically appropriate assessment after the identified fall. (506)

C) In January 2014, resident #400 had a fall, and the home's Resident Care Coordinator was unable to locate any post-fall assessment documentation. Interview with the front line staff confirmed a post-falls assessment was not completed after the identified fall. (586) [s. 49. (2)]

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 that a a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls after a resident sustains a fall., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (1) This section and sections 69 to 78 apply to,
(a) the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act; and O. Reg. 79/10, s. 68 (1).
(b) the organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there was an organized program of nutrition care and dietary services at the home.

A) On August 15, 2014 during a review of the dinner meal service, start time was noted to be 1700 hours in an identified dining room with 26 residents and four PSWs present.

i) Staff feeding a table of five residents (#406, #407, #408, #409 who required full assistance with eating, and #404 whose document the home refers to as the care plan stated limited assistance, though required full feeding during the meal observation), were observed several times having to stop feeding these residents and leave the table to assist other residents with clearing their plates and serving dessert and drinks. As a result, resident #406 was still being fed their entrée at 1810 hours.
ii) During service, the staff voiced concern about not being able to focus on feeding residents #406, #407, #408 and #409 because they often need to stop what they are doing to clear plates and serve desserts to other residents, resulting in these residents' food getting cold.
iii) Resident #410 left the dining room without eating dessert, stating it was taking too long to get their dessert.
iv) Resident #404 was encouraged to eat independently several times, though they kept falling asleep and would not lift their arms, therefore had their food sitting in front of them untouched until 1745 hours when a staff member came to feed them, at which time the resident consumed their entire meal. This staff member was also going back and forth between feeding residents #406 and #407 in addition to resident #404.
v) Three family members voiced concerns about residents not receiving the level of assistance they required while in the dining room due to insufficient staff available and the staff's workload during service. [s. 68. (1)]

2. The licensee did not ensure that the home's nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by the DOC. The home's "Weight/Height" Policy did not include the requirement to take the resident's heights annually, only upon admission. This was confirmed by the DOC. [s. 68. (2) (e) (ii)]

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 there is an organized program of nutrition care and dietary services at the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the food production system included standardized recipes and production sheets for all menus.

A) Review of the home's production sheets on August 14, 2014, demonstrated that they only encompassed the regular menu; there were no production values for the therapeutic menus, such as modified diabetic, restricted energy, or gluten-free. This was confirmed by the NSM.

B) The home's therapeutic menu extensions for August 14, 2014, stated that pureed

rice was to be served in place of pureed whole wheat bread, however there was no recipe for pureed rice available.

C) Resident #403 had an individualized gluten-free menu kept in the servery, however it did not include any standardized recipes or serving sizes to inform staff of the appropriate portions required for the resident.

D) The home's therapeutic menu extensions for lunch on August 14, 2014, stated that those receiving pureed diets are to receive pureed rice in place of pureed whole wheat bread. Observation of lunch dining service and interview with staff confirmed mashed potatoes and gravy were served in place of rice or bread. The staff stated that mashed potatoes and gravy are served every day as the pureed starch because the residents prefer this. There are no production values for mashed potatoes and it was not listed on the therapeutic menus in place of rice or bread. [s. 72. (2) (c)]

2. The licensee did not ensure the preparation of all menu items according to the planned menu.

A) The home's therapeutic menu sheets stated that those receiving restricted diabetic, energy controlled, or gluten-free diets were to receive chicken breast in place of chicken nuggets. Observation of the lunch meal production and lunch dining service and interview with staff confirmed that no chicken breast was prepared or available to the residents.

B) The home's therapeutic menu extensions for lunch on August 14, 2014, stated that those receiving pureed diets were to receive pureed rice in place of pureed whole wheat bread. Observation of lunch dining service and interview with staff confirmed no pureed rice was prepared. [s. 72. (2) (d)]

3. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The recipe for pureed toast stated bread was to be added to a food processor with hot water and seedless jam or butter and processed. Interview with staff confirmed pureed toast was prepared either by adding bread and milk to a food processor, or by soaking bread in milk. The recipe was not followed, affecting taste, appearance, and food quality. [s. 72. (3) (a)]

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 there is preparation of all menu items according to the planned menu, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that their Missing Clothing Policy was complied with.

Resident #007, #011, and #009 reported missing articles of clothing within the last year that were never found. The home's policy "Laundry Services, Missing Clothing" (revised August, 2011) stated that lost clothing was to be reported to the Laundry Department through the use of missing clothing slips that are stored at all nurses stations. Interview with the laundry staff revealed that they are informed of missing items through verbal communication by the front line staff. Interview with the front line staff on the south wing of the ground and second floors also confirmed that their lost clothing reporting procedure was through verbal communication only, and that no clothing slips are used or available in the home. Interview with the home's Director of Programs and Support Services (DPSS) revealed that the staff verbally report missing laundry directly to the DPSS via telephone, rather than to the Laundry Department or with the use of slips, and that not all staff were completing missing item concern forms. The home's policy was not being complied with. [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #403 was provided with food that was adequate in quantity and nutrition.

As per the home's regular lunch for August 14, 2014, a cheese, lettuce, and onion sandwich with salad or chicken nuggets with rice pilaf and peas was to be served. Interview with staff on August 14, 2014, and review of resident #403's individualized gluten-free menu, stated they were to receive cheese with either salad or peas. There was no starch included. The NSM stated the resident always refuses bread due to dislike; however, confirmed no other starches were offered for lunch such as rice or potatoes. Review of the resident's three week menu cycle demonstrated that there was a starch missing at each lunch meal. Review of the resident's clinical health records and interview with the RD confirmed the resident has experienced significant weight loss since May 2014. The NSM and RD confirmed the gluten-free lunch menu may not be nutritionally adequate. [s. 11. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system was easily seen, accessed and used by resident, staff and visitors at all times.

On August 13, 2014, the bedroom call bell attached to the resident's bed in an identified room was not functioning when pushed and therefore could not be activated. Staff confirmed that the call bell was broken and could not be activated. The communication and response system was inaccessible to the residents in the room. [s. 17. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A) The licensee did not ensure that the plan of care for resident #010 was based on an assessment of the resident's needs related to the type and level of assistance required related to activities of daily living.

i) During observation of resident #010 on August 14, 2014 at 1400, it was noted that the resident was lying in bed with two half side rails up on the top portions of the resident's bed.
ii) It was noted that there was a sign posted in the resident's room on the wall indicating that the resident was to have two half bed rails up when in their bed.
iii) The quarterly assessment completed on May 20, 2014, by the physiotherapist indicated that the resident used two bed rails in bed for mobility and transfers.
iv) The Minimum Data Set (MDS) assessment completed on May 15, 2014 by nursing staff also confirmed that the resident used two bed rails in bed.
v) During an interview with the registered staff on the resident's home area, they confirmed that the resident used two half bed rails when in bed to assist with their mobility in bed.
iv) A review of the document that the home referred to as the most current care plan revealed that there was no mention of the use of any bed rails for resident #010 or the reason for their use.
v) The registered staff interviewed confirmed that the use of the bed rails was not included in resident #010's care plan. (167) [s. 26. (3) 7.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee did not ensure that supplies were readily available at the home to meet the nursing and personal care needs of residents.

A concern was expressed by a family member that the staff appear to be searching for gloves and do not have enough gloves to provide resident care. Interviews with several of the nursing staff confirmed that the home does not provide access to gloves at all times as the gloves are locked in the medication room and the staff have to wait until a nurse is available to provide gloves. [s. 44.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items were offered to residents at each meal.

The home's menu stated that for all menus, milk was to be offered to residents. Observation of the dinner meal service on August 15, 2014, demonstrated that not all residents were offered milk as per the planned menu. The staff member interviewed stated that not all residents take milk, and that they are aware of those who do and do not, so only those residents who typically drink milk are given milk with dessert, and the rest of the residents are not offered any. [s. 71. (4)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure meal and snack times were reviewed by the Residents' Council.

An interview with the Residents' Council President on August 15, 2014 confirmed meal and snack times were not reviewed. Review of the Residents' Council meeting minutes from November 2013 to July 2014 did not provide documentation of review of the home's meal and snack times. Interview with the NSM and Residents' Council Assistant on August 18, 2014, confirmed review of the meal and snack times could not be verified. [s. 73. (1) 2.]

2. The licensee did not ensure course-by-course service of meals for each resident.

During the lunch meal on August 14, 2014, and dinner meal on August 15, 2014, staff members were observed serving the residents their desserts while several of them were still eating their entrees. [s. 73. (1) 8.]

3. The licensee did not ensure proper feeding techniques were used to assist residents with eating at meals.

During lunch meal observation on August 12, 2014, in an identified dining room, three staff members were observed feeding residents while standing up beside the residents. After the inspector inquired about this, one staff member retrieved a stool to sit on to continue feeding the resident; however, the other two staff members remained standing. Interview with the RD confirmed this is an unsafe feeding practice due to an increased risk of choking from head extension. The RD also confirmed they have witnessed this in the past and has informed the staff about the importance of feeding residents at eye-level for safety. Additionally, nursing staff confirmed dignity is not maintained when standing over a resident to feed them. [s. 73. (1) 10.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that resident #033 was screened for tuberculosis within 14 days of admission. Resident #033 was admitted to the home on an identified date in 2014 and the resident did not receive their tuberculosis screening until approximately two months later. This information was confirmed by the health record and the DOC. [s. 229. (10) 1.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 30 day of October 2014 (A1)

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

Marilyn Love

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MARILYN TONE (167) - (A1)

Inspection No. / No de l'inspection : 2014_201167_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-001078-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 30, 2014;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S HEALTH SYSTEM
99 Wayne Gretzky Parkway, BRANTFORD, ON, N3S-6T6

LTC Home / Foyer de SLD : ST JOSEPH'S LIFECARE CENTRE
99 WAYNE GRETZKY PARKWAY, BRANTFORD, ON, N3S-6T6

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : DERRICK BERNARDO

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his

or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30 day of October 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARILYN TONE - (A1)

Service Area Office /
Bureau régional de services : Hamilton