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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2016	2016_511586_0006	026643-16	Critical Incident System

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

JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 31, 2016

The following Critical Incident System (CIS) Inspection was completed: 0026643-16.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Manager of Quality, Performance and Projects, the Coroner, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed resident paper and electronic health records, internal investigation notes, relevant policies and procedures, departmental audit sheets and flow sheets.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care, strategies, and resident monitoring were developed and implemented for resident #001 based on the assessed needs of the resident with responsive behaviours.

On an identified date in 2016, progress notes revealed resident #001 was wandering throughout their home area. Several hours later, resident #001 was found in distress after having ingested a foreign substance from another resident's room.

Interview with PSW #200 and review of the resident's documented plan of care identified that they had a history of certain responsive behaviours which put them at risk of harm. Progress notes revealed that there were five occasions in 2016 where the resident exhibited one of their identified behaviours. All of these incidences occurred around the same time of day.

Progress notes and flow sheets revealed that the resident would exhibit one of their behaviours on a daily basis. PSW #200 and registered staff #112 confirmed that the resident would demonstrate more behaviours at a certain time of the day. Registered staff #112 and #111, along with progress notes, revealed that the resident was not easily redirected. The resident's plan of care identified that they were monitored hourly. The DOC confirmed that this was a standard in the home, but was not documented.

Items were brought into the home that contributed to resident #001's risks related to their behaviours, and the home's internal investigation notes confirmed that they were able to identify the source of these items. Interview with registered staff #111 and #112 and

PSW #200 confirmed that the staff had "no idea" that those items were in the home and unlocked. These staff confirmed that they were not aware of any relevant audits occurring in the home. PSW #200 confirmed that unless the items were left out, they would not have been identified, as there was no regular process in place for staff to check certain identified areas for any unlocked items.

In an interview with the DOC, they confirmed that random audits were completed, and resident #002's room was last audited for one week prior to the incident, where no items that posed risk were identified by staff. No other audits were completed for that particular area after that.

Review of progress notes revealed that counselling was completed in the past regarding the items that contributed to resident #001's risks related to their behaviour as per the home's policy. PSW #200 and the DOC confirmed that staff were aware of the source of these items in the past.

Interview with the DOC on August 30, 2016, confirmed that resident #001 had a significant and recent history of their identified behaviours. They confirmed that the resident was monitored hourly; however, more frequent monitoring and documentation could have been an intervention put into place prior to this incident, especially during a specific time of day.

The DOC also confirmed that the staff of the home were aware of the history of the items being brought into the home. They confirmed that there was no information included in the home's admission package regarding this responsibility of visitors, nor was there any information regarding this risk posted in the specific home area where resident #001 resided, who was at high risk. PSW #300 also confirmed that there was no information posted in the home area to alert visitors.

The DOC confirmed that due to the high risk of the resident, as well as the known history of the source of the items brought in, more frequent auditing of resident rooms, including all areas of the room, should have been implemented on that home area.

Registered staff #001 and 003, and the DOC, confirmed that resident #001 continued to pose a risk to themselves and therefore their plan of care should have been updated to include the interventions listed above, to ensure that the resident was protected from harm. [s. 53. (4) (b)]

Additional Required Actions:

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

Issued on this 21st day of September, 2016

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

Original report signed by the inspector.

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2016_511586_0006
Log No. / Registre no:	026643-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2016
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
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:

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

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that written approaches to care, strategies, and resident monitoring are developed and implemented for all residents in the home who are at risk of an identified responsive behaviour.

The plan shall include, but not be limited to:
1. The review of the plans of care and development of interventions to reduce their risk of an identified responsive behaviour, of any residents who exhibit this behaviour.
2. The development and implementation of global and/or home-area specific mechanisms to ensure that no items that pose risk are brought into the home without being labelled and secured in the appropriate area according to the home's policy.
3. The review and revision of any relevant policies and procedures.
4. Re-training for all staff on the relevant policies and procedures.
5. The development and implementation of auditing tools that identify potential relevant items in the home, such as home areas that have residents at high risk of coming in contact with these items, which include details on how to properly search resident home areas.
6. The development and implementation of resources for families and other visitors to the home on the importance of following the home's policy regarding bringing these items into the home.

The plan is to be submitted on or before the noted Compliance Order Due Date to Jessica Paladino by e-mail at Jessica.Paladino@Ontario.ca.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (3), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #401 experienced, the scope of one isolated incident, and the Licensee's history of non-compliance (WN) on the November 24, 2015 Resident Quality Inspection with the r. 53 related to the home's management of responsive behaviours.

The licensee failed to ensure that written approaches to care, strategies, and resident monitoring were developed and implemented for resident #001 based on the assessed needs of the resident with responsive behaviours.

On an identified date in 2016, progress notes revealed resident #001 was

wandering throughout their home area. Several hours later, resident #001 was found in distress after having ingested a foreign substance from another resident's room.

Interview with PSW #200 and review of the resident's documented plan of care identified that they had a history of certain responsive behaviours which put them at risk of harm. Progress notes revealed that there were five occasions in 2016 where the resident exhibited one of their identified behaviours. All of these incidences occurred around the same time of day.

Progress notes and flow sheets revealed that the resident would exhibit one of their behaviours on a daily basis. PSW #200 and registered staff #112 confirmed that the resident would demonstrate more behaviours at a certain time of the day. Registered staff #112 and #111, along with progress notes, revealed that the resident was not easily redirected. The resident's plan of care identified that they were monitored hourly. The DOC confirmed that this was a standard in the home, but was not documented.

Items were brought into the home that contributed to resident #001's risks related to their behaviours, and the home's internal investigation notes confirmed that they were able to identify the source of these items. Interview with registered staff #111 and #112 and PSW #200 confirmed that the staff had "no idea" that those items were in the home and unlocked. These staff confirmed that they were not aware of any relevant audits occurring in the home. PSW #200 confirmed that unless the items were left out, they would not have been identified, as there was no regular process in place for staff to check certain identified areas for any unlocked items.

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Interview with the DOC on August 30, 2016, confirmed that resident #001 had a

significant and recent history of their identified behaviours. They confirmed that the resident was monitored hourly; however, more frequent monitoring and documentation could have been an intervention put into place prior to this incident, especially during a specific time of day.

The DOC also confirmed that the staff of the home were aware of the history of the items being brought into the home. They confirmed that there was no information included in the home's admission package regarding this responsibility of visitors, nor was there any information regarding this risk posted in the specific home area where resident #001 resided, who was at high risk. PSW #300 also confirmed that there was no information posted in the home area to alert visitors.

The DOC confirmed that due to the high risk of the resident, as well as the known history of the source of the items brought in, more frequent auditing of resident rooms, including all areas of the room, should have been implemented on that home area.

Registered staff #001 and 003, and the DOC, confirmed that resident #001 continued to pose a risk to themselves and therefore their plan of care should have been updated to include the interventions listed above, to ensure that the resident was protected from harm. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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
Long-Term Care Inspections 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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 16th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Paladino

Service Area Office /
Bureau régional de services : Hamilton Service Area Office