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 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

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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
Feb 13, 2019	2019_573581_0002	029525-17, 029754-17, 025347-18	Critical Incident System

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 Lifecare Centre
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

DIANNE BARSEVICH (581)

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): January 30, 31, February 1, and 4, 2019.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Log #029754-17 was related to falls management.
Log #029525-17 was related to falls management.
Log #025347-18 was related to falls management.

The following Complaint Inspection was completed concurrently with this CIS Inspection:
Log #030461-18 was related to an injury of unknown cause.
Log #000075-19 was related to plan of care and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (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 failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A review of CIS submitted to the Director on an identified date in 2018, identified that resident #001 had a fall and sustained an injury.

On an identified date in 2018, resident #001 was observed to have an intervention in place. In an interview with PSW #106 and PSW #107, they stated the resident had an intervention in place.

The ADOC #103 was interviewed and acknowledged that resident #001 had the identified intervention in place since an identified date in 2018.

The ADOC #103 confirmed after reviewing the written plan of care with RN #112 that the identified intervention was not identified in the written plan of care as planned care for resident #001. [s. 6. (1) (a)]

2.The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A review of CIS submitted to the Director on an identified date in 2018, identified that resident #001 had a fall and sustained an injury.

Review of the current written plan of care identified the resident was transferred with an identified level of assistance. On an identified date in 2019, the resident's room was observed which identified a logo posted above the bed which did not clearly identify the transfer status.

In an interview with PSW #106 and PSW #107, they both stated the resident was transferred with an identified level of assistance. They acknowledged that the logo did not provide clear direction to PSW staff.

Review of the PSW observational flow sheets for an identified period of time in 2018 and 2019, identified the resident was transferred with a level of assistance.

During an interview with the ADOC #103, they stated that the logos posted in the residents' rooms were part of the written plan of care. After observing resident #001's logo and reviewing the written plan of care they confirmed that the written plan of care did not set out clear direction to staff and others who provided direct care to the resident related to how the resident #001 was to be transferred. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A review of CIS submitted to the Director on an identified date in 2018, identified that resident #001 had a fall and sustained an injury.

Review of the plan of care identified that resident #001 fell on an identified date in 2018 and sustained an injury which was treated. Review of the progress notes on another

date in 2018, identified that the home completed an assessment which identified that resident #001 sustained another injury.

Review of the Minimum Data Set (MDS) significant change in status assessment completed on an identified date in 2019, identified they fell in the past 30 days and in the past 31 to 180 days but did not indicate they had an injury in the last 180 days.

During an interview with ADOC #103, they stated the resident had fallen and sustained injuries in the past 180 days and confirmed the MDS assessment and another assessment completed by the home were not integrated and consistent with each other. [s. 6. (4) (a)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan were no longer necessary.

A. A review of a CIS submitted to the Director on an identified date in 2017, identified that resident #031 had a fall which resulted in an injury.

The current written plan of care was reviewed for resident #031 identified they had several interventions in place to prevent falls.

The resident's room was observed on an identified date in 2019 and the interventions identified in the written plan of care were not in place.

PSW #105 was interviewed and stated the resident no longer used the identified interventions.

In an interview with RPN #104, they stated the resident was not at risk of falling and no longer required the identified interventions. Review of the progress notes with RPN #104 identified on an identified date in 2018, an audit was completed and indicated that one of the interventions were no longer required; however, there was no documentation indicating when the other interventions was removed.

RPN #104 confirmed that the written plan of care was not reviewed and revised when the resident's care needs changed related to the falls interventions no longer needed.

B. A review of a CIS submitted to the Director on an identified date in 2018, identified

that resident #001 had a fall and sustained an injury.

The clinical records for resident #001 were reviewed and identified that prior to the fall they were transferred with an identified level of assistance. After the resident returned from the hospital, Restorative Coach #109 reassessed their transfers and documented in the progress notes that the level of assistance required was to be changed.

Review of the plan of care when the resident returned from hospital indicated the written plan of care was not revised with the new level of transfer.

RPN #110 was interviewed, reviewed the plan of care and acknowledged the resident's transfer status changed when they returned from hospital.

RPN #110 confirmed that the plan of care was not reviewed and revised when the resident returned from hospital and their care needs changed related to transfers. [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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changes or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the plan, policy, protocol, procedure, strategy or system was complied with.

The licensee failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48(1) 1 the licensee is required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the required programs includes policies, procedures and protocols.

The licensee's policy, "Head Injury Routine" (HIR), identified as policy number 1-NR-80, last revised July 2017 and included as part of the licensee's Falls Prevention and Management program directed, "this policy and procedure shall be initiated when: Resident reports he/she has been struck in the head; a resident is witnessed to have struck his/her head; a RN or RPN discovers evidence of a head injury or possible head injury; a resident has an unwitnessed fall".
The HIR was to be performed every 60 minutes for the first four hours and every four hours for the next 20 hours for a total of 24 hours and will be documented on the Glasgow Coma Scale form.

A review of a CIS submitted to the Director on an identified date in 2017, identified that resident #030 had a fall and sustained an injury.

A review of the clinical health record for resident #030 identified they had a fall and sustained an injury. The resident had another fall and sustained another injury.

A review of the Glascow Coma Scale form, for resident #030 identified that registered staff initiated a HIR post the identified falls, but did not fully complete the HIR as directed by the licensee's policy.

In an interview with RN #100, they confirmed that the HIR was not fully completed post the identified falls.

The licensee's HIR policy, post falls for resident #030 was not complied with. [s. 8. (1) (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 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 that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1.The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of a CIS submitted to the Director on an identified date in 2017, identified that

resident #031 had a fall which resulted in an injury.

The licensee's policy, "Elder Care Fall Prevention and Management", identified as policy number 1- NR-70, last revised August 31, 2017, directed registered nursing staff under the section, Post Fall Assessment and Management that when the resident was moved, they were to ensure that proper lifting procedures were performed (two person lift if the resident was able to weight bear, otherwise a two person lift using a mechanical lift).

A. The plan of care was reviewed and identified that resident #031 had a fall and was found on the floor, with identified injuries and assisted back to bed with staff. The resident was sent to hospital and was diagnosed with an injury.

In an interview with the ADOC #103, they acknowledged that staff were to follow the licensee's Fall Prevention and Management policy which directed registered staff to ensure that proper lifting procedures were performed. Specifically, if the resident was not able to weight bear a two person lift using the mechanical lift should have been used.

ADOC #103 confirmed that staff did not use safe transferring devices or techniques when assisting to transfer resident #031 post fall.

B. A review of the clinical health record for resident #030 identified they had a fall and sustained an injury. The resident had another fall and sustained another injury.

A review of the plan of care for resident #030, specifically the progress notes identified when the resident had fallen on an identified date in 2017, registered staff and PSWs transferred the resident who was not able to ambulate and weight bear without a mechanical lift.

During an interview with the ADOC #103, they stated the resident should have been transferred with the mechanical lift as instructed by the home's policy.
ADOC #103 confirmed that staff did not use safe transferring devices or techniques when transferring resident #030 post fall.

C. A review of a CIS submitted on an identified date in 2018, identified that resident #001 had a fall and sustained an injury.

The plan of care for resident #001 was reviewed and identified they had a fall and they were assisted with their transfer by staff. RN #108 was called to assess the resident and

documented that they immediately noted an injury and the resident was exhibiting obvious signs of injury. Resident #001 was sent to hospital for further assessment and was diagnosed with an injury requiring treatment.

The ADOC #103 stated that the resident should not have been transferred in the specified manner and acknowledged the staff did not follow the licensee's Falls Prevention and Management policy.

ADOC #103 confirmed that staff did not use safe transferring devices or techniques when assisting to transfer resident #001 post fall. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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 :

The licensee failed to ensure that when the resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of a CIS identified that on an identified date in 2017, resident #030 had a fall and sustained an injury.

Review of the clinical health record identified that resident #030 had a fall and sustained an injury. Review of the progress notes documented by RPN #102 identified the resident was complaining of identified symptoms. It was noted that resident was transferred with the assistance of staff.

Review of the Post Fall Assessment and the progress notes on the day of the fall identified there was no assessment completed prior to the resident transfer by staff.

During an interview with RN #100, they stated they were called to the unit by RPN #102 to assess the resident. They stated when they arrived the resident was already moved and the resident reported identified symptoms.

RN #100 confirmed they did not fully assess the resident and immediately called the substitute decision maker (SDM), the ambulance and the resident was sent out to hospital where they were diagnosed with an injury.

During an interview with ADOC #103, they stated that the post fall assessment was to be completed post fall and that all residents who had fallen were to be assessed where found prior to being moved or transferred by registered staff to ensure there were no injuries and that it was safe to move the resident.

ADOC #103 confirmed that when resident #030 had fallen that a post fall assessment was not completed by RPN #102 before the resident was transferred. [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 when the resident has fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The license failed to ensure that a written record was kept relating to each evaluation under paragraph three that included the date of the evaluation, the names of the persons, who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

ADOC #103 provided the annual program evaluation for the Fall Prevention Program completed for year 2018. The evaluation identified the summary of the changes made since the last review; however, did not identify the date the changes were implemented.

During an interview with ADOC #103, they confirmed they did not document the date those changes were implemented for the Falls Prevention program. [s. 30. (1) 4.]

WN #6: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Review of the plan of care identified that resident #001 had a fall on an identified date in 2018, was sent to hospital and was diagnosed with an injury. The resident returned to the home and was assessed as significant change in status.

The critical incident report that was submitted to the Director was submitted eight days after the incident occurred.

ADOC #103 confirmed in an interview that the critical incident report had not been submitted to the Director within the required time frames. [s. 107. (3)]

Issued on this 14th day of February, 2019

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

Original report signed by the inspector.