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
Jun 10, 2019	2019_648741_0013	006000-18, 006916-18, 017251-18, 025322-18, 025369-18, 028317-18	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

AYESHA SARATHY (741), SAMANTHA PERRY (740)

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): May 27-31, 2019

The following Critical Incidents (CI) were inspected as a part of this inspection:

Related to Falls Prevention:

CI #2976-000021-18/Log #025322-18
CI #2976-000023-18/Log #025369-18
CI #2976-000025-18/Log #028317-18
CI #2976-000016-18/Log #017251-18
CI #2976-000011-18/Log #006000-18
CI #2976-000009-18/Log #006916-18

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Health Care Aide (HCA), Registered Practical Nurses (RPNs), a Registered Nurse (RN), the Restorative Quality Coach, the Assistant Director of Care (ADOC), the Director of Care (DOC), and two residents.

During the course of the inspection, the inspector(s) also reviewed clinical records and plans of care for identified residents, observed two residents and reviewed internal investigation notes.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided

to a resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specified date related to the unwitnessed fall of an identified resident, that resulted in an injury and transfer to the hospital. The CI stated that the resident was found by a staff member in their room and that they were wearing slippery socks at the time of their fall.

The resident's care plan prior to the fall as well as their current care plan were reviewed on Point Click Care (PCC). It was stated under "Falls" and "Mobility" that staff were to ensure that the resident wore proper and non-slip footwear.

During interviews, a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) said that the identified resident did not have non-slip socks as the home did not provide them and family would have to purchase and bring them in. The PSW said that the resident owned their own socks but they were not non-slip socks. In an interview with the Restorative Quality Coach (RQC), they stated that the home provided non-slip socks for residents and families may purchase non-slip socks for residents if they did not like the socks provided by the home. The RQC said it was important for the identified resident to wear proper footwear and non-slip socks before their fall as well as currently because they have always been ambulatory. When asked why the home had not provided the resident with non-slip socks, they said they had not been made aware by staff that resident required them. In another interview, Assistant Director of Care (ADOC) said that the home provided slip resistant socks to residents if they did not have any of their own. They reviewed the resident's care plan on PCC and said that they should have had non-slip socks as it was an intervention in the care plan to ensure proper footwear. The RQC and ADOC agreed that the care set out in resident's plan of care had not been provided as specified in their plan.

2. During an observation of an identified resident's room, Inspector #741 noted that the resident had two bed rails in place on their bed and one rail was in the raised position. The resident was not in their room at the time of the observation. Also noted by Inspector #741 was a signage board posted next to the bedroom door that indicated "no bed rails".

The resident's current care plan was reviewed on Point Click Care (PCC) related to bed rails. Under "Mobility", an intervention stated that no bed rails or assist bars were required when resident was in bed.

During an interview with a PSW, they stated that one of the resident's interventions for falls prevention was to use bed rails. Inspector #741 and the PSW went into the resident's room together and the PSW reviewed the signage board next to the bedroom door. They said that the board indicated no bed rails to be used but stated that they always put bed rails up for the resident as they felt the resident needed them. They also said that the bed rails were always up when they came in for their shift in the morning and went to get the resident up for the day. The PSW acknowledged that they should not have been using bed rails for the resident according to the direction on the resident's signage board. In another interview, the ADOC reviewed the identified resident's care plan on PCC and said the care plan stated no bed rails were to be used when the resident was in bed. The ADOC acknowledged that staff had not followed the resident's signage board and care plan regarding the use of bed rails and that it was the home's expectation that they would.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 107. (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):
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.

Findings/Faits saillants :

1. The licensee has 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 a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

Ontario Regulation 79/10 s. 107 (7) defines "significant change" as a major change in the resident's health condition that,

(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) three business days after an identified resident had an unwitnessed fall that resulted in an injury and transfer to the hospital. The CI stated that the resident was found by a staff member on their bedroom floor and in pain, and was sent to the hospital for assessment.

The resident's care plan prior to their fall was reviewed on Point Click Care (PCC), and stated that the resident was at low risk for falls, self-transferred with supervision, was able to weight bear and was encouraged to use a walker.

The resident's progress notes were reviewed on PCC in relation to the fall and they indicated that the home received numerous updates from the hospital about the resident's status and that they were aware the resident underwent surgery the day after they were sent to the hospital. When the resident returned to the home they required a wheelchair and assistance by two staff for all transfers. The resident's care plan was updated after their fall and stated that their status had changed to a two person assist with constant supervision for transfers and toileting.

During interviews, a Personal Support Worker (PSW) and Registered Practical Nurse (RPN) said that the resident was independent prior to their fall and changed to a two person assist for transfers and toileting after the fall. In an interview with the Assistant Director of Care (ADOC), they said that the home's expectation is to report critical incidents where a resident has a fall, is sent to the hospital and sustains an injury within

one business day if they know there is a significant change. They acknowledged that the home did not report this critical incident to the MOHLTC in accordance with the LTCHA and O. Reg 79/10.

2. A Critical Incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) seven business days after an identified resident had an unwitnessed fall that resulted in an injury and transfer to the hospital. The CI stated that the resident was found by a staff member on their bedroom floor and in pain and subsequently sent to the hospital.

A review of the resident's care plan on Point Click Care (PCC) prior to their fall showed that the resident was at low risk for falls, self-transferred with supervision, was able to weight bear and walked independently though they were encouraged to use a walker.

Progress notes were reviewed on Point Click Care (PCC) in relation to the resident's fall, and indicated that the home received numerous updates from the hospital in regards to the resident's status. The resident returned to the home five days after being sent to the hospital and were noted to be lethargic, in pain and exhibited impaired skin integrity. A Physiotherapy assessment was completed which indicated that the resident would need assistance by two staff for all transfers, would be lifted manually and required a wheelchair for locomotion.

During interviews, a Personal Support Worker (PSW) said that the resident walked independently and did not need any assistance with care prior to their fall, however, their status changed to a two person assist for care, needed a wheelchair and a lift for transfers after their fall. The Assistant Director of Care (ADOC) acknowledged that the home did not report this critical incident to the MOHLTC in accordance with the LTCHA and O. Reg 79/10.

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 Director is immediately informed, in as much detail as is possible in the circumstances, of 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, followed by the report required, to be implemented voluntarily.

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.