

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

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
Nov 18, 2019	2019_541169_0023	003817-19, 018659-19	Complaint

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**Licensee/Titulaire de permis**

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

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

St. Joseph's Lifecare Centre  
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

YVONNE WALTON (169)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): September 26, 27, October 1, 2,3,5,8,9,10, November 6, 2019**

**The following intakes were completed in this Complaint Inspection:**

**Log #0118659-19 related to care, nutrition and hydration, dining, falls prevention, grooming, laundry and management of lost personal items**

**Log #003817-19 related to continence care and associated charges for incontinence products**

**During the course of the inspection, the inspector(s) spoke with the Interim President, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Finance, Administrative and HR Assistant, Ward Clerk and Admin support, RAI/MDS staff, Registered Dietitian (RD), Maintenance Staff, Nutrition and Environmental Manager (NEM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, residents and families.**

**The inspector observed care areas, dining rooms/meal service, reviewed clinical records, meeting minutes and policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Continence Care and Bowel Management**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Reporting and Complaints**

**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

**8 WN(s)**

**5 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 failed to ensure that resident #008 received the care set out in their plan of care.

Resident #008 received the wrong diet texture. The DOC and Nutrition and Environmental manager confirmed resident #008 did not receive the correct textured meal.

The licensee did not ensure that the care set out in resident #008's plan of care was provided to them. [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 that ensures that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
  - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
  - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was kept clean, specifically a resident's room and carpets on each floor, were not kept clean. Throughout the inspection, it was observed that the carpets were heavily soiled. Interview with the Nutrition and Environmental manager confirmed the carpets were heavily soiled.

During the inspection, a resident room was observed to have a strong smell throughout the room. Interview with the Nutrition and Environmental Manager confirmed the room had a significant smell.

The licensee failed to ensure that carpets in common areas and a resident room were kept clean. [s. 15. (2) (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 that ensures that, (a) the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning  
Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,  
(b) a between-meal beverage in the morning and afternoon and a beverage in the  
evening after dinner; and O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were offered a between-meal beverage in the morning.

Observation confirmed a nourishment cart was not prepared or served to any residents on four home areas in the mid morning.

A review of the food and fluid records for one month in 2019, identified did not receive a morning beverage for that month.

DOC and ESM confirmed the expectation that nourishment be provided to residents three times a day, including mid morning.

The licensee failed to ensure each resident was offered a minimum of a between-meal beverage each morning. [s. 71. (3) (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 that ensures each resident is offered a minimum of (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service Specifically failed to comply with the following:**

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**

- (a) procedures are developed and implemented to ensure that,**
  - (i) residents' linens are changed at least once a week and more often as needed,**
  - (ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
  - (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
  - (iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that personal items such as dentures and shoes were labelled within 48 hours of admission.

Interview with the family confirmed they were never asked about labelling personal items when the resident was admitted and nursing staff confirmed they did not label the items.

2. The licensee failed to ensure there was a process to report and locate residents' lost clothing and personal items. Resident #008 lost their personal items since admission to the home. and these were not identified on the home's log.

Interview with the NEM confirmed there wasn't a process to manage lost personal items, nor was there a record maintained of reported items.

Interview with the family confirmed the residents items remained lost during the inspection. [s. 89. (1) (a) (iv)]

***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 that ensures that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing, (iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and (iv) there is a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**

**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**

**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**

**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**

**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**

**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record was kept in the home that included:

(a) the nature of each verbal or written complaint

(b) the date the complaint was received

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required

(d) the final resolution, if any

(e) every date on which any response was provided to the complainant and a description of the response, and

(f) any response made by the complainant?

In 2019, a family member sent an email to the Director of Care and Assistant Director of Care expressing concerns regarding the care of a resident.

The ADOC, interim president and the physician had a conversation with the complainant to address concerns and put several processes in place to address the concerns.

A complaint log was not maintained in the home that included items (a-f) as identified above. This was confirmed by the DOC and ADOC. [s. 101. (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 That ensures the licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written complaint received concerning the care of a resident including staffing concerns.

The written complaint was received at the home, however was not forwarded to the Director.

Interview with the DOC and ADOC confirmed the written complaint concerning the care of a resident was not immediately forwarded to the Director. [s. 22. (1)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #008 received fingernail care, including the cutting of fingernails.

Observation made by the inspector confirmed the nails were unkempt, jagged, rough and long.

The licensee failed to ensure that resident #008 received fingernail care, including the cutting of fingernails. [s. 35. (2)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator  
Specifically failed to comply with the following:**

**s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:**

**1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).**

**2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).**

**3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure that the home's Administrator works regularly in the position on site for at least the following amount of time were week, at least 35 hours.

The home has a licensed capacity of 205 beds.

The DOC confirmed there wasn't an administrator that works regularly in the position on site and the position has been vacant for approximately 9 months. The current Interim President confirmed they have been covering the Administrator position since the previous Administrator resigned January 2019, however they also work at another home part time.

The home had been actively recruiting a new administrator and one was scheduled to start Oct 16, 2019. [s. 212. (1)]

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**Issued on this 20th day of November, 2019**

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

**Original report signed by the inspector.**