Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 27, 2020	2020_729615_0005	016821-19, 017898-19, 018519-19, 022990-19	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

HELENE DESABRAIS (615), CHERYL MCFADDEN (745)

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): February 12 and 13, 2020.

The following Critical Incident (CI) reports were inspected during the inspection:

CI #2976-000015-19/Log #018519-19 related to skin and wound care;
CI #2976-000014-19/Log #017898-19 related to prevention of abuse, neglect and retaliation;
CI #2976-000018-19/Log #022990-19 related to prevention of abuse, neglect and retaliation;
CI #2976-000012-19/Log #016821-19 related to prevention of falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, two Registered Nurses, one Restorative Quality Lead, one Registered Practical Nurse, three Personal Support Workers, a family member and residents.

The inspectors also reviewed clinical records and plan of care for the identified residents, policies and procedures, documentation related to the home's Fall Management program, the Skin Management Program, home's investigation notes and other relevant document.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
3 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	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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from the hospital.

A) On a specific date, the home submitted Critical Incident (CI) report #2976-000015-19/Log #018519-19 to the Ministry of Long Term Care related to an incident that caused an injury to a resident for which the resident was transferred to hospital.

The home's policy #1-NR-22 "Skin Risk Assessment", last revised September 8, 2019, stated in part "A Braden Scale and Head to Toe assessment are required within 24 hours upon return from hospital or if the resident has been away from the facility for more than 24 hours."

The home's policy #NR-197 "Skin and Wound Care Management Program", last revised December 8, 2019 stated, in part, under procedures "Registered staff will complete the skin risk assessment and head to toe assessment following any readmission from hospital."

Review of a resident's progress note in Point Click Care (PCC) on two different dates, stated in part that the resident had injuries on a specific part of their body.

Review of the resident's assessments tab in PCC had no documentation of a "Head to Toe Skin Assessment" completed when the resident returned from the hospital.

During an interview, the ADOC stated they were unable to find a Head to Toe Assessment for the resident, that it was not completed and expected they should have been completed.

The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff when exhibiting altered skin integrity and upon return from the hospital.

B) The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of a resident's progress note in PCC, on two different days, stated in part that the resident had injuries on specific parts of their body.

Review of the resident's assessments tab in PCC had no documentation of a completed "Head to Toe Skin Assessment" following the incident.

The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a

member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2)]

Additional Required Actions:

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

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 has failed 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 policy, protocol, procedure, strategy or system, that it was complied with.

On a specific date, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care (MLTC) related to resident physical abuse resulting in injuries, that occurred on the previous date.

Review of the home's policy #1-NR-70 "Elder Care Fall Prevention and Management" last reviewed December 8, 2019, stated in part "2.0 Post Fall Assessment and Management.
2.1. When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs.
2.2. Person witnessing the fall or finding the resident after the fall: Assess the environment, before mobilizing the resident, for cues as to objects which may have

struck the resident during the fall or cause the fall. Do not move the resident if there is suspicion or evidence of injury until a full head to toe assessment has been conducted and appropriate action determined. Notify the registered nursing staff.
2.3 Registered Nursing Staff: Move the resident, ensuring that the proper lifting procedures are performed. Observe for pain or difficulty weight bearing if no injury is evident.", and;
“Move the resident, ensuring that the proper lifting procedures are performed (2 person lift if the resident is able to weight-bear, otherwise a 2-person lift using a mechanical lift)."

Review of video footage of the incident with the Administrator, showed that after the incident, an RPN did not complete a full head to toe assessment before finishing their assessment, a PSW and a non-staff member were seen getting the resident up on their feet where the RPN finished their assessment.

During an interview after reviewing the video footage, the Administrator agreed that the resident should have had a full head to toe assessment before being transferred and that two staff members should have transferred the resident up as per the home's policy "Elder Care Fall Prevention and Management". [s. 8.]

2. On a specific date, the home submitted Critical Incident (CI) #2976-000018-19/Log #022990-19 to the MLTC, related to prevention of abuse.

A review of the CI revealed that a resident was found on specific day, with equipment normally used as a PASD that resident could operate, but this time the PASD was tempered with and was now a restraint.

Review of the home's policy #1-NR-135 "Philosophy - Restraint Use" last reviewed July 23, 2019, stated in part "If a resident is unable to remove the device by themselves either due to cognitive and or physical impairment, then the device is considered a restraint. Prohibited Devices: Sheets, wraps, tensors or other types of strips or bandages used other that for therapeutic purposes. Any device that cannot be immediately released by staff. Any device not intended for the purpose of restraining and/or that does not have manufacturer's directions supporting its use as a restraint."

During an interview, the ADOC stated that the tampered PASD was a restraint and policy should have been followed.

The licensee failed 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 policy, protocol, procedure, strategy or system, that it was complied with. The staff failed to comply with "Philosophy - Restraint Use"'s policy. [s. 8. (1)]

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 policy, protocol, procedure, strategy or system, that it is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where there was a written policy that promotes zero tolerance of abuse and neglect of residents, it was complied with.

On a specific day, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care (MLTC) related to prevention of abuse.

Review of the home's policy #1-NR-161 "Resident Abuse" Last reviewed May 2, 2018, stated in part "Reporting: In any case of abuse or suspected abuse, staff, students, volunteers or any other person witnessing or having knowledge of an incident will verbally report the incident IMMEDIATELY to their Supervisor, or during the evening and nights, to the delegate in charge of the facility."

During a record review of a resident's progress notes in Point Click Care (PCC), it was noted that six months earlier a resident was in the hallway crouching down and another co-resident pushed them to the floor.

A search in ltchomes.net portal showed no CI was submitted to the MLTC regarding the incident.

During an interview, the ADOC stated the incident six months earlier was abuse and staff should have reported it immediately to the management of the home. [s. 20. (1)]

2. On a specific date, the home submitted Critical Incident (CI) #2976-000018-19/Log #022990-19 to the MLTC, related to prevention of abuse that occurred four days earlier.

A review of the CI revealed that a resident was found on specific day, with equipment normally used as a PASD that resident could operate, but this time the PASD was tempered with and was now a restraint. Staff of the home only reported this incident to management via email four days later. The CI also included that the registered staff received education on immediate reporting of abuse.

During an interview, the ADOC stated the incident was abuse and staff should have reported it immediately to management by phone.

The licensee failed to ensure that where there was a written policy that promotes zero tolerance of abuse and neglect of residents, it was complied with. [s. 20. (1)]

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 there was a written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. 2007, c. 8, s. 75. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff.

Section 74 (2) of the LTCH Act 2007 c.8 defines “agency staff” as staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. 2007, c. 8, s. 74 (2).

Section 215 (1) O. Reg. 79/10 states that “This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

Section 215 (2) states that “The criminal reference check must be,
(a) conducted by a police force; and
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).
(3) The criminal reference check must include a vulnerable sector screen to determine the person’s suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. O. Reg. 79/10, s. 215 (3).
(4) The licensee shall require that the staff member or volunteer provide the licensee with a signed declaration disclosing the following with respect to the period since the date the person’s last criminal reference check under subsection (2) was conducted.

On a specific date, the home submitted Critical Incident (CI) #2976-000018-19/Log #022990-19 to the Ministry of Long Term Care, related to prevention of abuse.

During the inspection the inspector discovered that an agency staff was working in the home and was involved with the allegations of abuse of a resident.

During an interview, the Assistant Director of Care (ADOC) stated that three agency Personal Support Workers worked in the home. When asked if the home could provide the criminal reference check and the three agency Personal Support Worker's qualifications the ADOC could not provided them.

The licensee has failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff. [s. 75. (1)]

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 screening measures are conducted in accordance with the regulations before hiring staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

On a specific day, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care related to resident physical abuse resulting in injuries. At a later date, CI #2976-000014-19 was amended by the ADOC with a follow up of the on-going investigation.

A search in the ltchomes.net portal showed there were no amended CI to ensure the results of the abuse investigation were reported to the Director.

The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director. [s. 23. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On a specifc date, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care related to resident physical abuse resulting in injuries.

A review of the home's policy #1-NR-161 "Resident Abuse" last reviewed May 2, 2018, stated in part "Physical abuse: This represents infliction of physical pain wherein discomfort, pain, injury or threat of injury is a consequence. Physical abuse includes, but limited to: Attacking, Slapping, Shoving, Striking, Hitting, Kicking, Prodding, Rough Handling [...] Pushing."

Review of the home's investigation interviews the day after the incident, written by the Assistant Director of Care (ADOC) included the testimony of a RN had discussed with the ADOC the previous day of their concerns surrounding the incident and the concerns of a RPN at the time of the incident.

During interviews, the RN and PSW, both stated they attended to the resident after the incident. The RN and PSW both stated at that time of the incident they had suspicion it was abuse of the resident. The RN stated that they called the ADOC to report their suspicion of abuse and if police should be called. The RN said that they were told by the ADOC that they would look into it the following morning.

During an interview, the ADOC denied having any suspicion of abuse for the resident when the RN contacted them on the evening of the incident. The Administrator was present during the interview, and stated that they would of suspected abuse and would of reported it immediately to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident.

On a specific date, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care related to resident physical abuse resulting in injuries that occurred on the previous day.

A review of the CI indicated that the home contacted the resident's Power of Attorney (POA) to inform them of the physical abuse.

A review of the resident's progress notes in Point Click Care (PCC) on that date stated in part that the POA was informed of a different reason.

There was no documented evidence that the POA was informed of the physical abuse to the resident that resulted in injuries.

During a telephone interview with the Inspector and the resident's POA, they stated they remembered the Registered Nurse from the floor calling them to inform them of a different incident and were unaware if the resident had any injuries since admitted to the home.

The licensee failed to ensure that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident. [s. 97. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

The Criminal Code defined assault in section 265 (1) (a) A person commits an assault when without the consent of another person, he applies force intentionally to that other person, directly or indirectly.

The Criminal Code defined assault in section 265 (1) (b) A person commits an assault when (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose.

On a specific date, the home submitted Critical Incident (CI) #2976-000014-19/Log #017898-19 to the Ministry of Long Term Care related to resident physical abuse resulting in injuries that occurred the previous.

A review of the home's policy #1-NR-161 "Resident Abuse" last reviewed May 2, 2018, stated in part "Physical abuse: This represents infliction of physical pain wherein discomfort, pain, injury or threat of injury is a consequence. Physical abuse includes, but not limited to: Attacking, Slapping, Shoving, Striking, Hitting, Kicking, Prodding, Rough Handling [...] Pushing."

Review of the home's investigation included interviews on September 13, 2019, written by ADOC #101 included the following: "[RN] had come to see writer and [DOC #109] at 1500 also discuss why [they] had called writer the previous day. [RN #104] stated that staff had voiced concerns with the incident. PSW had informed [RN] that the [person] had a previous incident with another co-resident years ago. [RPN] expressed concerns is was abuse.

During interviews, the Registered Nurse (RN) and Personal Support Worker (PSW) both stated they attended to the resident after the incident and both stated at that time they had suspicion of abuse and suspicion a criminal offense had took place. The RN said that they called the ADOC to report their suspicions and if police should be called. The RN said that they were told by the ADOC that they would look into it the following morning and not to call the police.

During an interview, the ADOC denied having any suspicion of abuse for the resident when RN contacted them on the previous evening. The Administrator was present during the interview, and stated that they would of suspected abuse and police notified.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. [s. 98.]

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8	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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HELENE DESABRAIS (615), CHERYL MCFADDEN (745)
Inspection No. / No de l'inspection :	2020_729615_0005
Log No. / No de registre :	016821-19, 017898-19, 018519-19, 022990-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 27, 2020
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
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 :	Bidar Swamy

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 50 (2).

Specifically, the licensee must:

a) Ensure residents #001, #003 and any other resident who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

b) Ensure resident #003 and any other resident who exhibit altered skin integrity receive a skin assessment by a member of the registered nursing staff upon return of the resident from the hospital.

c) Ensure that the home’s Skin and Wound Management program policies and procedures are complied with regarding the completion and documentation of skin assessments for residents #001, #003, and any other resident who exhibit altered skin integrity.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from the hospital.

On a specific date, the home submitted Critical Incident (CI) report #2976-000015-19/Log #018519-19 to the Ministry of Long Term Care related to an incident that caused an injury to a resident for which the resident was transferred to hospital.

The home’s policy #1-NR-22 “Skin Risk Assessment”, last revised September 8, 2019, stated in part “A Braden Scale and Head to Toe assessment are required within 24 hours upon return from hospital or if the resident has been away from the facility for more than 24 hours."

The home’s policy #NR-197 “Skin and Wound Care Management Program”, last revised December 8, 2019 stated, in part, under procedures “Registered staff will complete the skin risk assessment and head to toe assessment following

any readmission from hospital."

Review of a resident's progress note in Point Click Care (PCC) on two different dates, stated in part that the resident had injuries on a specific part of their body.

Review of the resident's assessments tab in PCC had no documentation of a "Head to Toe Skin Assessment" completed when the resident returned from the hospital.

During an interview, the ADOC stated they were unable to find a Head to Toe Assessment for the resident, that it was not completed and expected they should have been completed.

The licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff when exhibiting altered skin integrity and upon return from the hospital.

2. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Review of a resident's progress note in PCC, on two different days, stated in part that the resident had injuries on specific parts of their body.

Review of the resident's assessments tab in PCC had no documentation of a completed "Head to Toe Skin Assessment" following the incident.

The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2)]

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was a pattern in the home and has the

possibility to impact a large number of residents. The home had no previous history of non-compliance in this area.
(745)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of February, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Helene Desabrais

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