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
Apr 26, 2021	2021_689586_0013	025497-20, 000976-21, 002083-21, 002852-21	Complaint

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

JESSICA PALADINO (586), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 18, 19, 22, 23, 24, 25, 26, 29, 30, 31 and April 8 and 9, 2021.

This inspection was completed with registered nursing student Olive Mameza Nenzeko in attendance on March 18 and 19, 2021.

The following Complaint inspections were completed:
025497-20 related to fall's prevention;
000976-21 related to fall's prevention, complaint response, nutrition, bathing and abuse;
002083-21 related to oral care; and,
002852-21 related to food production, nutrition, maintenance and wound care.

During the course of the inspection, the inspector(s) spoke with Vice President (VP), Director of Long-Term Care (DLTC), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Campus Lead, Nutrition and Environmental Manager (NEM), Registered Dietitian (RD), Brantford Public Health Unit, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, dietary aides (DA), residents and families.

During the course of the inspection, the inspector(s) completed an IPAC assessment, observed resident care and meal service and reviewed resident health records, complaint correspondence, security camera footage, program evaluations and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **5 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 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 the admission weight policies and procedures included in the required Nutrition Services Manual were complied with, for two residents.

LTCHA s.11 (1) requires an organized program of nutrition care and dietary services.

O. Reg. 79/10, s. 68 (2) (e) (i) requires that the program includes a weight monitoring system to measure and record weight on admission and monthly thereafter for each resident.

Specifically, staff did not comply with the home’s policy and procedure 'Weight Height Monitoring' or the 'Admission Checklist' internal procedure, indicating that a resident's weight must be taken within 24 hours of admission.

A) Resident #003 did not have their admission weight taken until 13 days after their admission to the LTCH. This was confirmed by the RD.

B) Resident #006 did not have their admission weight taken until five days after their admission to the LTCH. This was confirmed by the RD.

By not having an admission weight for the resident, a proper assessment of potential weight changes could not be completed to assist with identifying the need for any nutrition interventions.

Sources: residents #003's and #006's clinical records, the home's policy 'Weight Height Monitoring' (dated June 15, 2020) and procedure 'Admission Checklist' and interviews with resident #003's substitute decision-maker (SDM), RD, ADOC and DLTC. [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 any plan, policy, protocol, procedure, strategy or system implemented in accordance with applicable requirements under the Act is complied with, to be implemented voluntarily.

WN #2: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #017, #018 and #019, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

The home's 'Skin and Wound Management' policy required registered nursing staff to assess residents' wounds at least weekly

A. Resident #017 had an area of altered skin integrity and a review of the clinical record identified that weekly wound assessments were not completed by the registered staff consistently.

During a 16 week period, weekly wound assessments were not completed for the identified area of altered skin integrity on ten out of the 16 weeks. There was documentation that the resident refused to have an assessment completed on one date within that time frame; however, no further attempts to complete the assessment were documented.

B. Resident #018 had an area of altered skin integrity and a review of the clinical record identified that weekly wound assessments were not completed by the registered staff consistently.

During a six week period, weekly wound assessments were not completed for the identified area of altered skin integrity on three out of the six weeks.

C. Resident #019 had areas of altered skin integrity and a review of the clinical record identified that weekly wound assessments were not completed by the registered staff consistently.

During a six week period, weekly wound assessments were not completed for the identified area of altered skin integrity on three out of the six weeks.

The RN confirmed that the weekly wound assessments were not reassessed at least weekly for the identified residents.

The risk of not completing weekly wound assessments for residents #017, #018 and #019 was that the wounds could have worsened as the effectiveness of the wound care was not being evaluated.

Sources: skin and wound assessments of resident #017, #018 and #019, interview with the RN and the home’s policy 'Skin and Wound Management' (dated August 2019). [s. 50. (2) (b) (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 to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

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. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

In an interview with the NEM, they acknowledged that at the onset of the pandemic, to prevent staff from having to enter resident rooms, residents had not been offered a choice at their meals and PSWs chose meal options for them. Two PSWs confirmed they do not offer a choice to residents at meals and decide on their behalf.

This prevented residents from being able to choose their preference at each meal.

Sources: lunch meal observations, menu review and interviews with staff. [s. 71. (4)]

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 planned menu items were offered and available at each meal and snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the seven-day and daily menus were communicated to the residents.

A. An observation of four home areas identified that the television screens that were used to communicate the daily and weekly menus were not turned on.

On two of the units, the weekly menus that were posted had the wrong week displayed and there were none posted on the other two home areas. This was confirmed with two DAs at the time of the observation. (506).

B. Three home areas had only one menu option for lunch posted for the daily menu; the second option was listed as "see dietary".

The NEM acknowledged that the daily and weekly menu options were not communicated to the residents.

Sources: complaint intake #002852-21, dining room observations and interviews with staff. [s. 73. (1) 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 the home has a dining and snack service that includes, at a minimum, the communication of the seven-day and daily menus to residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's IPAC program was evaluated at least annually, in accordance with evidence-based practices (EPBs) or prevailing practices.

i. In an interview with the DLTC, they confirmed that the IPAC program was not evaluated in 2019.

ii. In the 2020 program evaluation, a goal was to review IPAC policies as required and update from Ministry Directives during COVID-19; however the DLTC acknowledged that this was not done. The IPAC Campus Manager also confirmed this had not been done.

Sources: review of the 2020 IPAC program evaluation and interview with the DLTC and IPAC Campus Manager. [s. 229. (2) (d)]

2. The licensee has failed to ensure that the home's 2020 IPAC program evaluation included a summary of changes and the dates those changes were made.

A review of the IPAC program evaluation date December 15, 2020, did not include a

summary of any changes made to the program, nor any dates changes were made. This was confirmed by the DLTC.

Sources: review of the 2020 IPAC program evaluation and interview with the DLTC and IPAC Campus Manager. [s. 229. (2) (e)]

3. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH before and after meals.

During observation on one home area, residents’ hands were not cleaned before lunch. A PSW acknowledged this and confirmed it was not done, nor was it done after meals. The IPAC Campus Manager confirmed it was an expectation of the staff to do so, but said this direction was not included in any of the home's policies.

The home’s HH program did not include a process for staff to assist residents to clean their hands before and after a meal. The failure to have a hand hygiene program in place in accordance with EBPs presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of meal service, interviews with staff, the home’s policy 'Hand Hygiene' (dated June 2020) and “Just Clean Your Hands” program resources. [s. 229. (9)]

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 licensee's infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; that a written record is kept relating to each evaluation under clause (d) 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; and that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint made to the DLTC concerning the care of resident #003 was responded to within 10 business days of receipt of the complaint, and that a response was made to the person making the complaint indicating what the licensee had done to resolve the complaint or how they believed the complaint to be unfounded and the reasons for the belief.

i. Resident #003's SDM e-mailed the DLTC requesting details on an incident that occurred in the home. Three days later, the DLTC responded to the e-mail; however, did not address or answer a specific question the SDM had asked regarding the resident.

ii. That same day, the SDM responded back, asking the question again; however, the DRC acknowledged that they did not respond back to the SDM.

The DLTC did not respond with the outcome of the internal investigation, nor acknowledge all of the SDM's concerns in the first e-mail, and did not respond to the second e-mail within 10 business days.

Sources: e-mail correspondence, the home's policy 'Complaints and Complaints' (dated May 2020) and interview with resident #003's SDM and DLTC. [s. 101. (1) 1.]

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.