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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 20, 2022	2022_988522_0004 (A4)	012405-21, 015464-21, 019124-21, 019169-21, 019256-21, 019484-21, 020926-21, 021104-21	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

Amended by JULIE LAMPMAN (522) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

A request was made by the Licensee to extend compliance due dates for COs #001, #005, #006, #007, #008, and #009 to September 12, 2022.

Issued on this 20th day of July, 2022 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by JULIE LAMPMAN (522) - (A4)

Amended 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 15, 16, 17, 18, 21,

22, 23, 24, 25, 28, 29, 30, 31, and April 1, 2022.

The following complaint intakes were inspected during this inspection:

Log #012405-21 related to resident care;

Log #015464-21 related to resident care, bathing and staffing;

Log #019124-21 related to resident care, staffing and the administration of drugs;

Log #019169-21 related to resident care and safety;

Log #019256-21 related to resident care and staffing;

Log #020926-21 related to staffing;

Log #021104-21 related to resident care.

Critical Incident Systems (CIS) report #2976-000046-21/Log #019484-21 related to neglect and bathing was also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Resident Care Manager, the Nutrition and Environmental Services Manager, the Director of Finance/Facilities, the Infection Prevention and Control Manager, the Director of Human Resources, Culture and Learning, the Staffing Coordinator, Registered Nurses (RNs), Registered Practical Nurses, Personal Support Workers (PSW), a PSW student, Agency RNs, Physicians, a Housekeeper, a Brant County Health Unit Public Health Inspector, the Brant County Health Unit Supervisor of Clinical Services, family members and residents.

Inspector(s) also reviewed resident clinical records, bathing schedules, the Nursing Daily Coverage Lists, the home's Staffing Contingency Plan, the home's complaints, medication incident reports, training records and policies and procedures relevant to this inspection.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

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

- **14 WN(s)**
- **6 VPC(s)**
- **9 CO(s)**
- **3 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. 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

A) A Critical Incident Systems (CIS) report was received by the Director in December 2021, related to a written concern received three days prior, from a resident's family member, which alleged the resident had missed multiple scheduled bathing days, which had occurred over a couple months.

The email from the resident's family member alleged that the resident was not getting the care they needed. In October 2021, the resident had received two scheduled bathing days and in November 2021, one scheduled bathing day, and one alternate form of bathing. The email stated the resident complained of discomfort and skin integrity issues due to lack of bathing.

The Director of Care (DOC) stated that they had not immediately reported the suspicion of improper or incompetent treatment or care of the resident as a CI to the Ministry of Long-Term Care (MLTC) until three days after the receipt of the complaint.

Sources: A CIS report, a complaint log, investigation notes, the home's "Critical Incident Report" policy and interview with staff.

B) A physician documented that a resident had been declining since the previous night and they had been at the home all day and had not been notified that the resident had been unwell.

The physician stated they expressed concern to the DOC that they were not informed of the resident's change in condition and that the resident had received medication when it was contraindicated.

The Assistant Director of Care (ADOC) stated they could not find that a CIS report had been submitted regarding the physician's concerns about the care of the resident.

Sources: Review of the resident's clinical record and interviews with staff.

C) A resident stated that they had submitted a written complaint to the DOC regarding improper treatment from a Personal Support Worker (PSW).

The written complaint from the resident indicated that a PSW refused to assist the resident with personal care as they were short staffed.

The DOC stated they did not submit a CIS report as they did not feel it was abuse or neglect.

Sources: Review of Complaints to the Director, the resident's written complaint, St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form, interviews with the resident and staff. [s. 24. (1)]

Additional Required Actions:

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

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

Several complaints were received by the Director between August and December 2021, related to many care concerns, residents not receiving baths and personal care, as well as concerns related to insufficient staffing levels in the home.

A) A resident missed three scheduled bathing days in November and December 2021.

B) Another resident stated at times when the home was short staffed, they did not get their scheduled bathing day. The resident missed eight scheduled bathing days from November 2021 to March 2022.

C) Another resident missed 11 scheduled bathing days from November 2021 to January 2022. On seven occasions, the resident was documented as receiving an alternate method of bathing which was not the resident's preference, as per their plan of care.

A registered staff member confirmed all three residents did not receive their scheduled bathing twice a week. They stated the one resident should have received their preferred method of bathing as per their plan of care.

Sources: Complaints to the Director, three residents' PSW/HCA Observational Flow Sheets and interviews with a resident and staff.

D) A resident missed 19 scheduled bathing days between October 2021 and March 2022. On two of those occasions, documentation indicated the resident had refused their scheduled bathing day.

E) Another resident missed 15 scheduled bathing days between October 2021 and March 2022. Documentation indicated the resident had refused their scheduled bathing day four times during that period.

The DOC confirmed that bathing was not consistently done twice weekly for the two residents. Inspector #577 received two decision trees from the Director of Care (DOC) titled "PSW and RPN Reduced Staffing Contingency Plan", implemented in draft July 16, 2021, which indicated that each floor was to have

four Personal Support Workers (PSWs). In the event where there was only three PSWs, staff were not to provide resident baths or bed making and were to dress residents where time permitted.

Two Personal Support Workers (PSWs) reported to Inspector #577 that the home had been short staffed during the previous six months. They stated that in October and November 2021, they were short staffed several times a week and resident baths were not given. One PSW reported that on scheduled resident bath days, staff were just getting the residents dressed and baths were not provided.

The Administrator advised Inspector #577 that they were aware of the many missed baths. The Administrator stated that they could not provide any documentation which indicated the home had a bathing contingency plan or that baths were rescheduled if they were missed or the resident refused; additionally, they stated that they did not have a specific ‘bath person’ because there would be no continuity of care.

Not receiving baths twice weekly put residents who were incontinent at risk for altered skin integrity. As part of a resident's weekly bath, PSWs were to make observations of resident's skin integrity and if baths were missed there was the potential to miss identifying areas of altered skin integrity for residents, in a timely manner.

Sources: Complaints to the Director, two residents' bathing records, two decision trees titled ‘Reduced Staffing Contingency Plans’ for PSWs and RPNS, implemented in draft July 16, 2021, investigation notes, and interviews with staff. [s. 33. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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).

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).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a verbal complaint made to the Director of Care (DOC) concerning the care of a resident was investigated and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to a resident, the investigation was commenced immediately.

An anonymous complaint was received by the Director regarding a resident's care.

In the resident's progress notes, the resident's physician documented that the resident had been declining since the previous night and they had been at the home all day and had not been notified that the resident had been unwell.

The physician stated they expressed concern to the DOC that they were not informed of the resident's change in condition and that the resident had received medication when it was contraindicated. The physician stated the DOC never followed up with them after they expressed their concerns.

A registered staff member stated they had administered the medication to the resident, and the DOC had not spoken with them regarding the physician's concerns.

The Assistant Director of Care (ADOC) stated they could not find documentation of the physician's complaint, the investigation or follow up.

Sources: The resident's clinical record and interviews with staff. [s. 101. (1) 1.]

2. 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 in turn by the complainant.

Several complaints had been received by the Director regarding staffing and care of residents in the home.

A) A CIS report was received by the Director related to a written concern received three days earlier, from a resident's family member, which alleged that the resident had missed multiple scheduled bathing days which had occurred over a couple months.

Inspector #577 reviewed the complaint form with the Administrator related to care concerns from the resident's family member. The Administrator confirmed that the complaint form had not included written action taken to resolve the complaint, date of action, time frame for actions to be taken, any follow up action required, final resolution, dates of any responses to the complainant, description of the response and any response made by complainant.

Sources: A CIS report, a complaint log, the home's "Compliments, Concerns and Complaints" policy, a complaint form, an email thread from the resident's family member, and interview with staff.

B) A physician told Inspector #522 that they had called and expressed concern to the DOC regarding the care of a resident. The physician stated they had not been called when the resident had a change in condition and had been administered medication when it was contraindicated.

C) Email complaints to the DOC and the Administrator, from two family members noted concerns regarding no nurse on the floor, staffing concerns and care provided to residents on a Home Area (HA), which was in a COVID-19 outbreak at that time.

The Assistant Director of Care (ADOC) stated there was no documentation regarding the complaints, or the complaint from the Physician. The ADOC was only able to provide a complaint log from January to April 2021.

Sources: The home's "Compliments, Concerns and Complaints" policy, the home's complaint log for 2021, email complaints from two family members and interviews with staff. [s. 101. (2)]

3. The licensee has failed to ensure the documented record of complaints received was reviewed and analyzed for trends, at least quarterly.

Inspector #522 requested the home's review of the home's complaints received for analysis and trends. The Administrator stated that there was no log kept past April 2021. The Administrator stated complaints were not reviewed and analyzed for trends, as management had not met about the complaints.

Sources:Interviews with staff. [s. 101. (3)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 documented record is kept in the home that includes, (c) the type of action taken to resolve a 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 is provided to the complainant and a description of the response; and (f) any response made in turn by the complainant; and the documented record of complaints received is reviewed and analyzed for trends, at least quarterly, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a medication incident involving a resident was documented, corrective action was taken, and a written record was kept.

A resident had received a medication when it was contraindicated.

The resident's physician stated the medication was contraindicated for the resident and they had expressed concerns to the Director of Care (DOC) regarding this.

A registered staff member stated they had administered the medication to the resident and that no one had spoken with them regarding the medication incident.

The Assistant Director of Care (ADOC) stated a medication incident had not been completed for the administration of the medication to the resident and there was no documentation of the incident or follow up with staff.

By not completing a medication incident report and following up with the registered staff member, other residents were at risk to potentially receive the medication when it was contraindicated.

Sources: The resident's clinical record, the Product Monograph for the medication dated June 9, 2021, and interviews with staff. [s. 135. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

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 all staff participated in the implementation of infection prevention and control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on March 14, 2022, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTCHs were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including daily symptom screening of residents and proper use of Personal Protective Equipment (PPE).

Review of the home's "Routine Infection Control Practices" policy stated Additional Precautions were to be followed as per signage. Droplet and Contact Precautions in Addition to Routine Practices signage noted staff were to wear personal protective equipment (PPE) which included a mask and eye protection within two metres of a resident.

Ministry of Health and Long-Term Care (MOHLTC) Control of Respiratory Infectior Outbreaks in Long Term Care Homes states, “LTCHs must ensure that staff has sufficient supplies of, and quick, easy access to the PPE required.”

A) Observations on two separate days, noted additional precaution signage posted outside a resident’s room. On both occasions, there was missing PPE on the isolation cart. Additional precaution signage were posted outside another resident’s room. There was also missing PPE on the isolation cart.

Three staff members confirmed there was missing PPE on the isolation carts and stated the required PPE should have been on the isolation carts.

Sources: IPAC tour of the home, review of two residents' clinical records, the home's "Routine Infection Control Practices" policy, Ministry of Health and Long-Term Care (MOHLTC) Control of Respiratory Infection Outbreaks in Long Term Care Homes dated November 2018, and interviews with staff.

B) A Resident Care Manager (RCM) was observed seated in a resident’s room across from the resident who was on additional precautions. The RCM was observed without the appropriate PPE.

The RCM stated that they were not providing direct care and had not worn the required PPE.

Brant County Public Health Inspector (BCPHI) #121 stated since additional precautions was a COVID-19 protocol requirement and there was a high community prevalence of COVID-19, best practice would be that staff wear the required PPE when they were in a resident’s room for more than a transient amount of time.

Staff not implementing the home's IPAC program by not wearing appropriate PPE and having appropriate PPE available on isolation carts, put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: IPAC tour of the home, review of a resident’s clinical records, the home's "Routine Infection Control Practices" policy, and interviews with BCPHI #121 and staff. [s. 229. (4)]

2. The licensee has failed to ensure that staff on every shift recorded symptoms of

infection in residents and took immediate action as required.

Two residents developed signs and symptoms compatible with an infection. There was no documentation to support that the residents were placed in isolation.

The IPAC Manager acknowledged that the residents had not been placed in isolation or on the home's line listing when they displayed signs and symptoms compatible with an infection.

Not placing residents with signs and symptoms compatible with an infection in isolation, put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: Two residents' clinical records, the home's line listings, the home's "Outbreak Management for COVID-19" policy, Directive #3 for LTCHs under the LTCH Act, 2007, the COVID-19 Guidance Document for LTCHs in Ontario, and interviews with staff. [s. 229. (5) (b)]

3. The licensee has failed to ensure that the home's hand hygiene (HH) program was implemented in accordance with the Ontario evidence-based HH program, Just Clean Your Hands (JCYH) to support resident and staff HH when entering and leaving a common gathering area of the home.

Review of the "Just Clean Your Hands" Implementation Guide stated alcohol-based hand rub (ABHR) should be available in common areas where residents gather, so residents, staff and visitors can clean their hands.

During an Infection Prevention and Control (IPAC) tour of the home ABHR was not observed in resident lounges on six home areas.

The IPAC Manager confirmed there was no ABHR available in the resident lounges and that ABHR should be available in resident lounges.

BCPHI #121 stated ABHR should be available in resident lounges for staff and visitors to perform HH if they were to assist a resident.

Not having access to ABHR in resident lounges put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: IPAC observations of the home, the JCYH Implementation Guide, the home's "Hand Hygiene Practices" policy, and interviews with BCPHI #121 and staff. [s. 229. (9)]

Additional Required Actions:

CO # - 005, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005,007

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that a resident was protected from neglect.

O. Reg. 79/10, s. 5. defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Several anonymous complaints were submitted to the Ministry of Long-Term Care (MLTC) regarding the care of a resident.

The home also received a complaint from the resident's family member regarding allegations of improper care towards the resident.

The resident had a medical emergency and there was a delay until registered staff attended to the resident. A Registered Nurse (RN) was notified and did not assess the resident.

In interviews, several staff members stated that specific medical interventions were not attempted on the resident.

The home did not have documentation to support any staff called the physician the day of the incident.

The resident's physician stated when the resident had a medical emergency, they would have expected registered staff to attempt specific medical interventions.

The Director of Care (DOC) stated they did not interview all staff who were present during their investigation and that specific information from the home's investigation was not kept. Although the DOC could not actually determine what happened to the resident, the DOC stated that they had told the resident's family member that there was no concerns regarding the care provided by staff.

The resident suffered actual harm through repeated inaction when a registered staff member did not immediately come when called, did not perform specific medical interventions, and the RN did not assess the resident. The resident was further neglected by inaction on the part of the DOC who failed to ask critical questions during the home's investigation, did not interview all staff present, and although they could not actually determine what happened to the resident, told the resident's family member there was no concern with the care provided. The Critical Incident Systems report submitted to the MLTC also noted that there was no concern of improper care.

Sources: A resident's clinical record, MLTC complaints, a CIS report, Patient Clinical Report from Brantford General Hospital, Brant/Brantford Paramedical Service Ambulance Call report, St. Joseph's Lifecare Centre "Tell Us How We Are

Doing" form, the home's investigation notes, and interviews with staff. [s. 19. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

WN #7: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, (b) clearly set out what constituted abuse and neglect, and (d) contained an explanation of the duty under section 24 of the Act to make mandatory reports.

During a review of the home's "Resident Abuse" policy, Inspector #577 found missing components that were required to be in their policy.

The Administrator and Inspector #577 reviewed the home's abuse and neglect policy, and the legislative requirements for the policy. The inspector found that the home's policy had not clearly defined emotional, verbal or sexual abuse. Additionally, neglect was not clearly defined. The policy also did not include an explanation of the duty under section 24 of the Act to make mandatory reports.

Sources: The home's "Resident Abuse" policy and an interview with staff. [s. 20. (2)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 008

WN #8: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Several complaints were received by the Director between August and December 2021, related to many care concerns, residents not receiving baths and personal care, as well as concerns related to insufficient staffing levels in the home.

A) Inspector #577 reviewed a resident's care plan which indicated that the resident was to receive two scheduled bathing days a week. A review of the bath list indicated the resident received two different methods of bathing a week.

Personal Support Workers (PSWs) advised Inspector #577 that the resident preferred a specific method of bathing twice a week and stated that the care plan and bath list was not updated.

The resident and their family member advised Inspector #577 of the resident's bathing preference, which was different from the resident's care plan.

B) Inspector #577 reviewed an additional resident's care plan which indicated that the resident was to receive a specific method of bathing twice a week. A review of the bath list indicated the resident received two different methods of bathing a week.

The resident's family member advised Inspector #577 of the resident's bathing preference, which was different from the resident's care plan.

PSWs advised Inspector #577 of the resident's bathing preference twice a week. Inspector #577 reviewed the care plan and bath list with the PSWs and they reported that the care plan should be updated to indicate the residents' preference.

A registered staff member indicated that registered staff were responsible to update the care plans.

Sources:
Complaints to the Director, two residents' care plan and bath lists, interview with a resident and their family member, a resident's family member and staff.

C) During an interview, a resident told Inspector #522 their bathing preference.

Review of the Home Area (HA) bath list and the resident's care plan noted that the resident's preferred bathing method was different than what the resident indicated.

A PSW reviewed the HA's bath list and confirmed that the bath list did not indicate the resident's correct method of bathing.

Sources:
Review of the resident's clinical records, the HA bath list, and interviews with the resident and staff. [s. 6. (2)]

2. A) The licensee failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of

the resident so that their assessments were integrated, consistent with, and complemented each other.

i) A resident had a change in condition and received a medication that was contraindicated which caused a significant impact to the resident's health.

A registered staff member stated they had given the medication to the resident. The registered staff member stated staff did not tell them about the resident's change in condition, and in hindsight they should not have given the medication to the resident.

Not reviewing assessments of the resident and administering the medication to the resident when it was contraindicated, put the resident at actual risk.

ii) Further review of the resident's progress notes noted there were no documented assessments from the Registered Nurse (RN) on days, after the night RN documented the resident's change in condition.

The resident's physician indicated in a progress note that they had been at the home all day and had not been notified of the resident's change in condition.

An RN acknowledged they had given a specific treatment to the resident due to their change in condition and would have reported this to the oncoming RN.

A registered staff member acknowledged they had not called the RN or the resident's physician to report the resident's change in condition on the day shift.

There was actual risk of harm to the resident, as staff did not collaborate on their assessments of the resident, the day RN did not assess the resident who had a change in condition on the night shift, and the resident's physician was not called in a timely manner.

Sources: The resident's clinical record, and interviews with staff.(522)

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

A resident had a change in condition which worsened throughout the day. A registered staff member notified an RN of the resident's change in status. The resident had declined further and was not assessed by an RN until the evening shift. At that time, an Agency registered staff called the resident's family for direction on whether the resident required additional medical intervention.

There was no documentation to indicate that the resident's physician had been notified of the resident's change in condition.

A registered staff member stated they were notified of the resident's change in condition near shift change, started the resident on a treatment, and notified an RN. The RN stated they did not assess the resident as it was the end of their shift and they would have told the oncoming RN what staff had reported to them.

The resident was at risk for actual harm when the RN and an Agency registered staff failed to promptly assess the resident who had a change in condition; staff did not call the resident's physician; and when the Agency registered staff waited until the resident had further declined, then sought direction from the family on whether the resident required additional medical intervention.

Sources: The resident's clinical records and interviews with staff. [s. 6. (4) (a)]

3.The licensee has failed to ensure that care was provided as per the residents' plan of care.

A) A resident had an order to have monitoring twice daily.

Review of the resident's electronic Medication Administration Record (eMAR) noted the resident had not been monitored on the day shift on a specific date.

B) A resident was to have their monthly vital signs completed the same day each month. Review of the resident's eMAR noted the resident did not have their vitals taken on the specific date, as ordered, or the remainder of the month.

A registered staff member reviewed the eMARs and clinical records for the two residents and confirmed care had not been completed, as ordered.

Sources: Review of two resident's clinical records, and interviews with staff. [s. 6. (7)]

4. The licensee has failed to ensure that the administration of medication to three residents was documented in the residents' eMAR.

A complaint was received by the Director related to staffing concerns and the administration of medication.

Two residents' eMARs noted a medication was not documented as administered for both residents on an evening shift in December 2021.

Another resident's eMAR noted a medication was not documented as administered for the resident on an evening shift in December 2021.

The Assistant Director of Care (ADOC) reviewed the residents' eMARs for December 2021, and acknowledged the above medications had not been signed as administered. The ADOC stated they had not received any medication incident reports related to medications not being administered to the residents.

Sources: Clinical records for three residents, and interview with staff. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 009

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 residents' plans of care are based on their bathing preferences, vital signs are taken as per residents' plans of care and the administration of medication for residents is documented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an adequate program of personal support services for the home to meet the assessed needs of residents.

Several complaints were received by the Director between August and December 2021, related to many care concerns, residents not receiving baths and personal care, as well as concerns related to insufficient staffing levels in the home.

A review of Personal Support Worker (PSW) staffing levels for the home with Staffing Coordinator #133 noted the following:

October 1 to 31, 2021, there was a PSW staffing shortage for 29 out of 31 days, 93 per cent (%).
November 1 to 30, 2021, there was a PSW staffing shortage for 28 out of 30 days (93%).

December 1 to 31, 2021, there was a PSW staffing shortage for 29 out of 31 days (93%).

Two PSWs reported to Inspector #577 that the home had been short staffed during the previous six months. They stated that in October and November 2021, they were short staffed several times a week and resident baths were not given. A PSW advised that on scheduled resident bath days, staff were just getting the residents dressed and baths were not provided.

The Director of Care (DOC) advised that up until January 7, 2022, the home did not have a staffing contingency plan and provided the "Contingency Staffing Plan" approved January 10, 2022. The DOC advised that the home had followed 'draft' decision trees titled ‘Reduced Staffing Contingency Plans’ for Personal Support Workers (PSWs) and Registered Practical Nurses (RPNs), dated July 16, 2021.

The Administrator advised that previous to July 16, 2021, the home did not have a written contingency plan for staffing and followed their "Staffing Plan" policy. The policy indicated that if there were shortages in any department, the manager or supervisor and/or manager on call were to be contacted to determine the coverage that was required based on the care needs of the home's residents. They further reported that the "PSW Reduced Staffing Contingency Plan", implemented in draft July 16, 2021, indicated that each floor was to have four PSWs. In the event where there were only three PSWs, staff were not to provide resident baths or bed making and were to dress residents where time permitted. Further, they advised that they were aware of the many missed baths, and they could not provide any documentation which indicated the home had a bathing contingency plan or that baths were rescheduled.

The “Contingency Staffing Plan” dated January 7, 2022, was implemented January 10, 2022, which specifically addressed staffing shortages and actions to be utilized for specific staffing scenarios.

Further findings detailing the insufficient personal support services in the home are specified in a written notification related to O. Reg. 79/10, s. 33 (1).

Sources: Complaints to the Director, daily coverage sheets from October 31 to December 31, 2021, the home’s "Staffing Plan" policy, two decision trees titled ‘Reduced Staffing Contingency Plans’ for PSWs and RPNS, implemented in draft July 16, 2021, “Contingency Staffing Plan” effective January 7, 2022, interviews

with staff. [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 there is an adequate program of personal support services for the home to meet the assessed needs of residents, to be implemented voluntarily.

WN #10: 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 concerning the care of a resident or operations of the home was immediately forwarded to the Director.

A) Review of emails from two family members to the Director of Care (DOC) and the Administrator noted concerns that there was no nurse on the floor, staffing concerns and concerns regarding care provided to residents on a specific Home Area (HA), which was in an outbreak at that time.

The Assistant Director of Care (ADOC) stated they could not find any record that the complaints from the two family members regarding the care of residents was submitted to the Director.

B) A resident stated to Inspector #522 that they had submitted a written complaint to the DOC regarding improper treatment from a Personal Support Worker (PSW).

The DOC stated they followed up on the resident’s complaint but did not submit the complaint to the Director. When Inspector #522 requested a copy of the resident’s complaint, the DOC stated they could not find the complaint the resident submitted to them.

Sources: Review of the home’s “Compliments, Concerns and Complaints” policy, St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form, email complaints from two family members, a written complaint from a resident and interviews with a resident and staff.

C) A Critical Incident Systems (CIS) report was received by the Director in December 2021, related to a written concern from a resident’s family member, which alleged the resident had missed multiple scheduled bathing days, which had occurred over a couple months.

The DOC advised that they had not immediately forwarded the written complaint to the Director until three days after they had received the complaint.

Sources: A CIS report, a complaint log, an email thread from a resident’s family member and interviews with a resident’s family member and staff. [s. 22. (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 written complaints concerning the care of a resident or operations of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contained procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected; (c) identified measures and strategies to prevent abuse and neglect;
(d) identified the manner in which allegations of abuse and neglect would be investigated, including who would undertake the investigation and who would be informed of the investigation; and
e) identified the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that might lead to abuse and neglect and how to avoid such situations.

During a review of the home's "Resident Abuse" policy, Inspector #577 found missing components that were required to be in their policy.

The Administrator and Inspector #577 reviewed the home's abuse and neglect policy, and the legislative requirements for the policy. The inspector found that the home's policy had not included the training and retraining requirements for all staff which included training on the relationship between power imbalances between staff and residents, and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected were not identified; measures and strategies to prevent abuse and neglect were not identified; and the manner in which allegations of abuse and neglect would be investigated, including who would undertake the investigation and who would be informed of the investigation was not identified.

Sources:
The home's "Resident Abuse" policy and an interview with staff. [s. 96.]

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 the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; (c) identifies measures and strategies to prevent abuse and neglect; (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents.

Several complaints were received by the Director between August and December 2021, related to many care concerns, residents not receiving baths and personal care.

Inspector #577 conducted a record review of the home's "Resident Abuse" policy.

The Administrator acknowledged that the last review and revision of the "Resident Abuse" policy was in August 2020.

Sources:
Several complaints to the Director, the home's "Resident Abuse" policy and an interview with staff. [s. 99. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A resident stated to Inspector #522 that they had submitted a written complaint to the DOC regarding improper treatment from a Personal Support Worker (PSW).

A review of St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form noted the Resident Care Manager spoke with the resident and indicated the resident was upset by the events.

The Administrator stated that after the investigation into the resident's complaint the staff member was to apologize to the resident for how they treated the resident.

Sources: Review of the resident's written complaint, St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form, interviews with the resident and staff. [s.3. (1) 1.]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

Review of the home's "Compliments, Concerns and Complaints" policy noted the following in part:

"When receiving written or email feedback, contact the resident/family to discuss the intention of the communication and to verify that the feedback is a complaint. For LTC clients'/families, ask the client/family if they would like SJLCB to submit their written complaint to the Ministry of Health and Long-Term Care. SJLCB will only submit written complaints to the MOHLTC at the request of clients'/families."

Inspector #522 reviewed LTCHA 2007 s. 22 (1)`with the Administrator. The Administrator acknowledged that only submitting written complaints to the Ministry of Long-Term Care at the request of the family was not in accordance with LTCHA 2007, which stated that any written complaint concerning the care of a resident or the operation of the long-term care home should be immediately forwarded to the Director.

Sources: The home's "Compliments, Concerns and Complaints" and an interview with staff. [s. 21.]

Issued on this 20th day of July, 2022 (A4)

[redacted]

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

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

Ordre(s) de l'inspecteur

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JULIE LAMPMAN (522) - (A4)
Inspection No. / No de l'inspection :	2022_988522_0004 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012405-21, 015464-21, 019124-21, 019169-21, 019256-21, 019484-21, 020926-21, 021104-21 (A4)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 20, 2022(A4)
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 :	Cheryl Raycraft

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ordre(s) de l'inspecteur

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 :

LTCHA, 2007 S.O. 2007, c.8, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 24 (1).

Specifically, the licensee must:

A) Ensure a person who has reasonable grounds to suspect neglect or improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon which it is based to the Director.
B) Review and revise the home's complaint policy to include that a written complaint concerning the care of a resident or the operation of the long-term care home shall be immediately forwarded to the Director.
C) Ensure that all staff receive training on the home's revised complaints policy.
D) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

A) A Critical Incident Systems (CIS) report was received by the Director in December 2021, related to a written concern received three days prior, from a resident’s family member, which alleged the resident had missed multiple scheduled bathing days, which had occurred over a couple months.

The email from the resident's family member alleged that the resident was not getting the care they needed. In October 2021, the resident had received two scheduled bathing days and in November 2021, one scheduled bathing day, and one alternate form of bathing. The email stated the resident complained of discomfort and skin integrity issues due to lack of bathing.

The Director of Care (DOC) stated that they had not immediately reported the suspicion of improper or incompetent treatment or care of the resident as a CI to the Ministry of Long-Term Care (MLTC) until three days after the receipt of the complaint.

Sources: A CIS report, a complaint log, investigation notes, the home's "Critical Incident Report" policy and interview with staff.

B) A physician documented that a resident had been declining since the previous night and they had been at the home all day and had not been notified that the resident had been unwell.

The physician stated they expressed concern to the DOC that they were not informed of the resident’s change in condition and that the resident had received medication when it was contraindicated.

The Assistant Director of Care (ADOC) stated they could not find that a CIS report had been submitted regarding the physician’s concerns about the care of the resident.

Sources: Review of the resident’s clinical record and interviews with staff.

C) A resident stated that they had submitted a written complaint to the DOC regarding improper treatment from a Personal Support Worker (PSW).

The written complaint from the resident indicated that a PSW refused to assist the resident with personal care as they were short staffed.

The DOC stated they did not submit a CIS report as they did not feel it was abuse or neglect.

Sources: Review of Complaints to the Director, the resident's written complaint, St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form, interviews with the resident and staff.

An order was made by taking the following factors into account:

Severity: There was no risk to residents by not reporting improper or incompetent treatment or care of residents to the Director.

Scope: The scope of this non-compliance was widespread.

Compliance History: The home had previous noncompliance to the same subsection of LTCHA 2007. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2022(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 33 (1).

Specifically, the licensee must:

A) Ensure that residents are bathed, at a minimum, twice a week by their preferred method as identified in their plan of care, or more frequently as per their plan of care.
B) Develop a bathing contingency plan to ensure residents receive scheduled bathing twice weekly when the home is short staffed.
C) Train all Personal Support Workers and registered staff on the bathing contingency plan.
D) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.
E) Develop and implement an auditing process for bathing care to ensure care is being provided in accordance with the preferences in the residents' plans of care. A documented record of this auditing must be maintained in the home. The auditing must continue until the Compliance Order (CO) has been complied.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

Several complaints were received by the Director between August and December 2021, related to many care concerns, residents not receiving baths and personal care, as well as concerns related to insufficient staffing levels in the home.

A) A resident missed three scheduled bathing days in November and December 2021.

B) Another resident stated at times when the home was short staffed, they did not get their scheduled bathing day. The resident missed eight scheduled bathing days from November 2021 to March 2022.

C) Another resident missed 11 scheduled bathing days from November 2021 to January 2022. On seven occasions, the resident was documented as receiving an alternate method of bathing which was not the resident's preference, as per their plan of care.

A registered staff member confirmed all three residents did not receive their scheduled bathing twice a week. They stated the one resident should have received their preferred method of bathing as per their plan of care.

Sources: Complaints to the Director, three residents' PSW/HCA Observational Flow Sheets and interviews with a resident and staff.

D) A resident missed 19 scheduled bathing days between October 2021 and March 2022. On two of those occasions, documentation indicated the resident had refused their scheduled bathing day.

E) Another resident missed 15 scheduled bathing days between October 2021 and March 2022. Documentation indicated the resident had refused their scheduled bathing day four times during that period.

The DOC confirmed that bathing was not consistently done twice weekly for the two residents. Inspector #577 received two decision trees from the Director of Care (DOC) titled "PSW and RPN Reduced Staffing Contingency Plan", implemented in draft July 16, 2021, which indicated that each floor was to have four Personal Support Workers (PSWs). In the event where there was only three PSWs, staff were not to provide resident baths or bed making and were to dress residents where time

permitted.

Two Personal Support Workers (PSWs) reported to Inspector #577 that the home had been short staffed during the previous six months. They stated that in October and November 2021, they were short staffed several times a week and resident baths were not given. One PSW reported that on scheduled resident bath days, staff were just getting the residents dressed and baths were not provided.

The Administrator advised Inspector #577 that they were aware of the many missed baths. The Administrator stated that they could not provide any documentation which indicated the home had a bathing contingency plan or that baths were rescheduled if they were missed or the resident refused; additionally, they stated that they did not have a specific 'bath person' because there would be no continuity of care.

Not receiving baths twice weekly put residents who were incontinent at risk for altered skin integrity. As part of a resident's weekly bath, PSWs were to make observations of resident's skin integrity and if baths were missed there was the potential to miss identifying areas of altered skin integrity for residents, in a timely manner.

Sources: Complaints to the Director, two residents' bathing records, two decision trees titled 'Reduced Staffing Contingency Plans' for PSWs and RPNS, implemented in draft July 16, 2021, investigation notes, and interviews with staff.

An order was made by taking the following factors into account:

Severity: Residents who were incontinent were at risk for altered skin integrity. By not receiving scheduled bathing twice weekly, staff had the potential to miss identifying areas of altered skin integrity in a timely manner.

Scope: The scope of this non-compliance was widespread.

Compliance History: The home had no previous noncompliance to this section of LTCHA 2007. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 2022(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee must be compliant with O. Reg. 79/10, s. 101. (1).

Specifically, the licensee must:

A) Ensure that verbal complaints made to the licensee or staff concerning the care of a resident is investigated and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to a resident, the investigation is commenced immediately.
B) Ensure that the verbal complaint made by the identified physician regarding the resident's care is documented, investigated, and a response provided to the identified physician.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that a verbal complaint made to the Director of Care (DOC) concerning the care of a resident was investigated and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to a resident, the investigation was commenced immediately.

An anonymous complaint was received by the Director regarding a resident's care.

In the resident's progress notes, the resident's physician documented that the resident had been declining since the previous night and they had been at the home all day and had not been notified that the resident had been unwell.

The physician stated they expressed concern to the DOC that they were not informed of the resident’s change in condition and that the resident had received medication when it was contraindicated. The physician stated the DOC never followed up with them after they expressed their concerns.

A registered staff member stated they had administered the medication to the resident, and the DOC had not spoken with them regarding the physician’s concerns.

The Assistant Director of Care (ADOC) stated they could not find documentation of the physician’s complaint, the investigation or follow up.

Sources: The resident’s clinical record and interviews with staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents by not investigating the complaint, as there was the potential for the same circumstances to occur.

Scope: The scope of this non-compliance was isolated.

Compliance History: The home had previous noncompliance to the same subsection of O. Reg. 79/10 s. 101. (522)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 15, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 135 (2).

A) Specifically, the licensee must ensure the medication incident involving a resident and all other medication incidents, are documented, corrective action is taken as necessary; and a written record is kept.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure a medication incident involving a resident was documented, corrective action was taken, and a written record was kept.

A resident had received a medication when it was contraindicated.

The resident's physician stated the medication was contraindicated for the resident and they had expressed concerns to the Director of Care (DOC) regarding this.

A registered staff member stated they had administered the medication to the resident and that no one had spoken with them regarding the medication incident.

The Assistant Director of Care (ADOC) stated a medication incident had not been completed for the administration of the medication to the resident and there was no documentation of the incident or follow up with staff.

By not completing a medication incident report and following up with the registered staff member, other residents were at risk to potentially receive the medication when it was contraindicated.

Sources: The resident's clinical record, the Product Monograph for the medication dated June 9, 2021, and interviews with staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to other residents of receiving the medication when it was contraindicated by the home not documenting the medication incident and following up with the registered staff member.

Scope: The scope of this non-compliance was isolated.

Compliance History: The home had previous noncompliance to this section of O. Reg. 79/10. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 15, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (4).

Specifically, the licensee must:

A) Ensure all isolation carts are supplied with all required PPE and are placed near resident rooms where additional precautions are in place.
B) Ensure all staff wear appropriate personal protective equipment (PPE) when in contact with residents on additional precautions.
C) Ensure the Resident Care Manager receives retraining on PPE requirements for residents on additional precautions.
F) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participated in the implementation of infection prevention and control (IPAC) program.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and most recently revised on March 14, 2022, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTCHs were at immediate and

increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents, including daily symptom screening of residents and proper use of Personal Protective Equipment (PPE).

Review of the home's "Routine Infection Control Practices" policy stated Additional Precautions were to be followed as per signage. Droplet and Contact Precautions in Addition to Routine Practices signage noted staff were to wear personal protective equipment (PPE) which included a mask and eye protection within two metres of a resident.

Ministry of Health and Long-Term Care (MOHLTC) Control of Respiratory Infection Outbreaks in Long Term Care Homes states, "LTCHs must ensure that staff has sufficient supplies of, and quick, easy access to the PPE required."

A) Observations on two separate days, noted additional precaution signage posted outside a resident's room. On both occasions, there was missing PPE on the isolation cart. Additional precaution signage were posted outside another resident's room. There was also missing PPE on the isolation cart.

Three staff members confirmed there was missing PPE on the isolation carts and stated the required PPE should have been on the isolation carts.

Sources: IPAC tour of the home, review of two residents' clinical records, the home's "Routine Infection Control Practices" policy, Ministry of Health and Long-Term Care (MOHLTC) Control of Respiratory Infection Outbreaks in Long Term Care Homes dated November 2018, and interviews with staff.

B) A Resident Care Manager (RCM) was observed seated in a resident's room across from the resident who was on additional precautions. The RCM was observed without the appropriate PPE.

The RCM stated that they were not providing direct care and had not worn the required PPE.

Brant County Public Health Inspector (BCPHI) #121 stated since additional precautions was a COVID-19 protocol requirement and there was a high community prevalence of COVID-19, best practice would be that staff wear the required PPE

when they were in a resident's room for more than a transient amount of time.

Staff not implementing the home's IPAC program by not wearing appropriate PPE and having appropriate PPE available on isolation carts, put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: IPAC tour of the home, review of a resident's clinical records, the home's "Routine Infection Control Practices" policy, and interviews with BCPHI #121 and staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents and staff by not having the required PPE readily available at resident rooms who were in isolation and by staff not wearing appropriate PPE when residents were in isolation under additional precautions.

Scope: The scope of this non-compliance was widespread.

Compliance History: The home had previous noncompliance to a different subsection of O. Reg. 79/10 s. 229. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2022(A4)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 19 (1).

Specifically, the licensee must ensure:

A) The identified registered staff member receives training on responding to residents who have a specific medical emergency.
B) The Director of Care (DOC), Assistant DOC and any other members of management that would complete complaint investigations into resident care, receive training on how to investigate allegations of neglect and improper treatment or care, including documentation and saving specific information.
C) Develop a policy on responding to residents who have a specific medical emergency. All Registered Staff will receive training on the new policies.
C) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was protected from neglect.

O. Reg. 79/10, s. 5. defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Several anonymous complaints were submitted to the Ministry of Long-Term Care (MLTC) regarding the care of a resident.

The home also received a complaint from the resident's family member regarding allegations of improper care towards the resident.

The resident had a medical emergency and there was a delay until registered staff attended to the resident. A Registered Nurse (RN) was notified and did not assess the resident.

In interviews, several staff members stated that specific medical interventions were not attempted on the resident.

The home did not have documentation to support any staff called the physician the day of the incident.

The resident's physician stated when the resident had a medical emergency, they would have expected registered staff to attempt specific medical interventions.

The Director of Care (DOC) stated they did not interview all staff who were present during their investigation and that specific information from the home's investigation was not kept. Although the DOC could not actually determine what happened to the resident, the DOC stated that they had told the resident's family member that there was no concerns regarding the care provided by staff.

The resident suffered actual harm through repeated inaction when a registered staff member did not immediately come when called, did not perform specific medical interventions, and the RN did not assess the resident. The resident was further neglected by inaction on the part of the DOC who failed to ask critical questions during the home's investigation, did not interview all staff present, and although they could not actually determine what happened to the resident, told the resident's family member there was no concern with the care provided. The Critical Incident Systems report submitted to the MLTC also noted that there was no concern of improper care.

Sources: A resident's clinical record, MLTC complaints, a CIS report, Patient Clinical Report from Brantford General Hospital, Brant/Brantford Paramedical Service Ambulance Call report, St. Joseph's Lifecare Centre "Tell Us How We Are Doing" form, the home's investigation notes, and interviews with staff.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

An order was made by taking the following factors into account:

Severity: There was actual risk to the resident by the staff members' inaction.

Scope: The scope of this non-compliance was isolated.

Compliance History: The home had no previous noncompliance to this section of LTCHA 2007. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 12, 2022(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 229 (5) (b).

Specifically, the licensee must:

A) Ensure any resident who displays signs and symptoms compatible with an infection is isolated, as required.
D) Ensure all registered staff receive retraining on the requirements for isolation related to signs and symptoms compatible with an infection.
F) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and took immediate action as required.

Two residents developed signs and symptoms compatible with an infection. There was no documentation to support that the residents were placed in isolation.

The IPAC Manager acknowledged that the residents had not been placed in isolation or on the home’s line listing when they displayed signs and symptoms compatible with an infection.

Not placing residents with signs and symptoms compatible with an infection in isolation, put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19.

Sources: Two residents' clinical records, the home’s line listings, the home's “Outbreak Management for COVID-19” policy, Directive #3 for LTCHs under the LTCH Act, 2007, the COVID-19 Guidance Document for LTCHs in Ontario, and interviews with staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to residents and staff by not isolating residents who displayed signs and symptoms compatible with an infection.

Scope: The scope of this non-compliance was a pattern.

Compliance History: The home had previous noncompliance to a different subsection of O. Reg. 79/10 s. 229. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 12, 2022(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be compliant with LTCHA 2007, s. 20. (2).

Specifically the licensee must:

A) Review and revise the home's abuse policy to include the following components:
i) Clearly define what constitutes abuse and neglect;
ii) An explanation of the duty under section 24 of the Act to make mandatory reports;
iii) Procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
iv) Measures and strategies to prevent abuse and neglect;
v) The manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation;
v) Identify the training and retraining requirements for all staff, including, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations
B) Ensure that all staff receive training on the revised written policies to promote zero tolerance of abuse and neglect of residents.
C) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers and materials taught.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, (b) clearly set out what constituted abuse and neglect, and (d) contained an explanation of the duty under section 24 of the Act to make mandatory reports.

During a review of the home's "Resident Abuse" policy, Inspector #577 found missing components that were required to be in their policy.

The Administrator and Inspector #577 reviewed the home's abuse and neglect policy, and the legislative requirements for the policy. The inspector found that the home's policy had not clearly defined emotional, verbal or sexual abuse. Additionally, neglect was not clearly defined. The policy also did not include an explanation of the duty under section 24 of the Act to make mandatory reports.

Sources: The home's "Resident Abuse" policy and an interview with staff.

An order was made by taking the following factors into account:

Severity: There was risk to residents as the home's abuse and neglect policy did not clearly define what constituted emotional, verbal or sexual abuse and neglect. There were actual incidents where neglect had not been investigated and/or reported to the Director.

Scope: The scope of this non-compliance was isolated.

Compliance History: The home had no previous noncompliance to this subsection of LTCHA 2007. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2022(A4)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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: 009

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (4) (a).

Specifically:

A) That a resident's physician is notified when the resident has a change in condition and the notification is documented;
B) When a resident has a change in condition they are assessed in a timely manner by the Registered Nurse and the assessment is documented;
C) When a resident has a change in condition and requires additional medical intervention, that they receive the medical intervention in a timely manner;
D) Residents are assessed prior to receiving a specific medication to ensure the resident does not receive the medication when it is contraindicated.

Grounds / Motifs :

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

i) A resident had a change in condition and received a medication that was contraindicated which caused a significant impact to the resident's health.

A registered staff member stated they had given the medication to the resident. The registered staff member stated staff did not tell them about the resident's change in condition, and in hindsight they should not have given the medication to the resident.

Not reviewing assessments of the resident and administering the medication to the resident when it was contraindicated, put the resident at actual risk.

ii) Further review of the resident's progress notes noted there were no documented assessments from the Registered Nurse (RN) on days, after the night RN documented the resident's change in condition.

The resident's physician indicated in a progress note that they had been at the home all day and had not been notified of the resident's change in condition.

An RN acknowledged they had given a specific treatment to the resident due to their change in condition and would have reported this to the oncoming RN.

A registered staff member acknowledged they had not called the RN or the resident's Physician to report the resident's change in condition on the day shift.

There was actual risk of harm to the resident, as staff did not collaborate on their assessments of the resident, the day RN did not assess the resident who had a change in condition on the night shift, and the resident's Physician was not called in a timely manner.

Sources: The resident's clinical record, and interviews with staff.

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

A resident had a change in condition which worsened throughout the day. A registered staff member notified an RN of the resident's change in status. The

resident had declined further and was not assessed by an RN until the evening shift. At that time, an Agency registered staff called the resident's family for direction on whether the resident required additional medical intervention.

There was no documentation to indicate that the resident's physician had been notified of the resident's change in condition.

A registered staff member stated they were notified of the resident's change in condition near shift change, started the resident on a treatment, and notified an RN. The RN stated they did not assess the resident as it was the end of their shift and they would have told the oncoming RN what staff had reported to them.

The resident was at risk for actual harm when the RN and an Agency registered staff failed to promptly assess the resident who had a change in condition; staff did not call the resident's physician; and when the Agency registered staff waited until the resident had further declined, then sought direction from the family on whether the resident required additional medical intervention.

Sources: The resident's clinical records and interviews with staff.

An order was made by taking the following factors into account:

Severity: There was actual risk to a resident as staff did not collaborate with each other in their assessments of the resident which resulted in the resident not being assessed by the RN and not receiving additional medical intervention, in a timely manner.

There was actual harm to a resident as staff did not collaborate with each other in their assessments of the resident which resulted in the resident receiving a medication that was contraindicated and caused a significant change in the resident's health status.

Scope: The scope of this non-compliance was a pattern.

Compliance History: The home had previous noncompliance to a different subsection of LTCHA 2007, c.8 s. 6. (522)

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This order must be complied with by /
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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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

Ontario

Ministry of Long-Term Care

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Order(s) of the Inspector

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

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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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

Order(s) of the Inspector

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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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 20th day of July, 2022 (A4)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by JULIE LAMPMAN (522) - (A4)

Ontario

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