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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 28, 2022
Inspection Number 2022_1459_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Joseph's Health System, Hamilton, ON

Long-Term Care Home and City
St. Joseph's Lifecare Centre, Brantford, ON

Lead Inspector
Ina Reynolds (524)

Additional Inspector(s)
Susan Crann (741069)

Inspector Digital Signature
Ina Reynolds
Digitally signed by Ina Reynolds
Date: 2022.09.29 08:42:18 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 31, September 1, 2 and 6, 2022

The following intake(s) were inspected:

- Intake # 010064-22 (CIS # 2976-000039-22) related to medication administration
- Intake # 010184-22 (Complaint) related to medication administration and cares & services
- Intake # 011489-22 (Follow-up) to CO#002 from inspection #2022_988522_0004 related to r. 33. (1), CDD Aug 15, 2022
- Intake # 011490-22 (Follow-up) to CO#003 from inspection #2022_988522_0004 related to r. 101. (1), CDD Jul 15, 2022
- Intake # 011491-22 (Follow-up) to CO#004 from inspection #2022_988522_0004 related to r. 135. (2), CDD Jul 15, 2022
- Intake # 011838-22 (Complaint) related to medication administration.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 33. (1)	2022_988522_0004	002	524
O. Reg. 79/10	r. 101. (1)	2022_988522_0004	003	524
O. Reg. 79/10	r. 135. (2)	2022_988522_0004	004	524

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Reporting and Complaints
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 102. (2)(b)

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued April 2022 related to the proper use of Personal Protective Equipment, including appropriate selection, application and disposal.

Specifically, the licensee has failed to ensure that staff members complied with safe techniques when applying, removing and wearing Personal Protective Equipment (PPE).

Rationale and Summary
Upon entry to the Long-Term Care home, inspector witnessed a staff member wearing a surgical mask incorrectly exposing their nose while walking through the main lobby passing other staff members, residents and visitors.

While inspecting the home units, multiple staff were observed wearing surgical masks incorrectly, crossing the straps at the ears leaving gaps in the seal of the mask at the cheek. There were boxes of surgical masks with pictures and instructions of how to wear a mask correctly and the instructions were not followed. There were numerous signs posted illustrating instructions on donning and doffing PPE.

While inspecting on a home area, which was in Covid-19 outbreak, inspector witnessed a Personal Support Worker (PSW) leave the outbreak unit with a N95 mask and eye protection on, then removed the eye protection without doing hand hygiene and left in the elevator wearing the used N95 and carrying the used eye wear.

The Director of Care (DOC) acknowledged the expectations of masking and following policy and procedures. The DOC stated in the interview it was an expectation that PPE be removed, hand hygiene was to be completed and a surgical mask was to be applied before going to any other area.

Impact was determined to be low as there was no direct harm to residents.

Sources: Halyard Fluidshield Procedure mask instructions on box; Public Health for Universal Mask use in Health care (Covid-19); St. Joseph's Lifecare Centre Policy 1-CO-11 Policy: Eye protection and universal masking, dated June 16, 2021; Signage: Donning and Doffing.

WRITTEN NOTIFICATION POLICIES

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 140. (6)

The licensee has failed to ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with a resident.

Rationale and Summary
A complaint was reported to the Ministry of Long-Term care regarding the administration of medications to a resident in the home. The complainant was concerned that medication was not administered to the resident.

Record review of Point Click Care (PCC) progress notes documented multiple occasions that medications were found and not administered to the resident. The complainant also found medications in the resident's room which was stated in the telephone interview with the inspector.

The home's "Medication Administration Pass" policy with revised date August 15, 2018, directed staff to observe the resident to ensure the medication had been swallowed.

A Registered Nurse (RN) stated that medications had been left in the resident's room. The Director of Care (DOC) stated that medications are not to be left in a resident's room and it was an expectation that the registered staff witness the resident swallow the medications.

The resident was at low risk for negative clinical outcomes related to this as no documentation of change of condition or concern was noted in the progress notes in PCC.

Sources: PCC documentation, CareRX policy #4.6 Medication Administration Pass revised date August 15, 2018, procedure #9. Interviews with the DOC, RN, and telephone interview with a complainant.

COMPLIANCE ORDER [CO#001] ADMINISTRATION OF DRUGS

NC#001 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 140. (1)

The Inspector is ordering the licensee to:

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FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 140. (1)

Specifically, the licensee must ensure:

A) All registered staff are administering medications to a resident following the rights of medication administration including the right resident and right medication, using two resident identifiers.

Grounds

The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Rationale and Summary

A complaint and critical incident was reported to the Ministry of Long-Term Care regarding the medication management for a resident in the home. A resident was administered medications by an Agency Registered Practical Nurse (RPN). Shortly after, the RPN realized the resident had been administered multiple medications which were not prescribed for them, as they had given another resident's medications by mistake.

Staff then identified that the resident's condition had changed, and the resident required medical treatment. After having been treated, the resident recovered to baseline.

Review of the critical incident and the medication incident report identified factors related to this medication error.

The home's policy titled "Medication Administration Pass" directed staff to ensure that "at least two person-specific client identifiers must be used to ensure resident receive the medication intended for them (e.g. recent photo on eMAR, resident ID bracelet, date-of-birth, asking the resident their name or ask another staff member to identify resident)".

The Assistant Director of Care (ADOC) and the Resident Care Manager both acknowledged that the RPN did not verify the resident's identity using two patient identifiers and just used the resident's name alone. The RPN was no longer working in the home as a result of the incident. The ADOC stated that staff are to follow the expected practices to ensure the right medications were administered to the right resident using two identifiers.

The resident was at high risk for negative clinical outcomes related to this medication error as the resident required medical treatment.

Sources: Info Line Complaint; Critical Incident (CI) report; the resident's clinical records; the home's policy titled "Medication Administration Pass" Policy No. 4.6 with revised date August 15, 2018; Medication Incident/Near Miss Report; and interview with the Assistant Director of Care, Resident Care Manager and other staff.

This order must be complied with by September 30, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

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Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.