Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

Original Licensee Report

Report Issue Date: March 3, 2023	
Inspection Number: 2023-1459-0003	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Lifecare Centre, Brantford	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2023.03.02 16:09:58 -05'00'
Additional Inspector(s) Barbara Grohmann (720920)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 11, 12,13, 16,17,18, 20, 23, 24, and January 25, 2023.

The following intakes were inspected:

- Intake: #00012348-IL-06799-HA - Complainant with concerns regarding resident Neglect.
- Intake: #00013547-Follow-up #: 1 – Window accessibility, O.Reg. 246/22 - s. 19.
- Intake: #00014483- [CI: 2976-000076-22] - Fall of resident.
- Intake: #00015136- [2976-000078-22] - Fall of resident.

The following intakes were completed:

- Intake: #00001338- [CI: 2976-000050-21] - Fall of resident.
- Intake: #00003417- [CI: 2976-000024-21] - Fall of resident.

- Intake: #00003864- [CI: 2976-000026-21] - Fall of resident.
- Intake: #00003952- [CI: 2976-000019-21] - Fall of resident.
- Intake: #00004524- [CI: 2976-000045-21] - Fall of resident.
- Intake: #00004917- [CI: 2976-000048-21] - Fall of resident.
- Intake: #00004984- [CI: 2976-000051-21] - Fall of resident.
- Intake: #00005320- [CI: 2976-000006-22] - Fall of resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Compliance Order #1 from Inspection #2023-1459-0003 related to O.Reg. 246/22, s. 19 inspected by Barbara Grohmann (720920)

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

Infection Prevention and Control
Safe and Secure Home
Resident Care and Support Services
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
A) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, specifically regarding transfers.

Rationale and Summary
A resident requested to be toileted. PSW attempted to transfer them to their wheelchair; however, when the resident went to sit down, they missed the wheelchair and fell on the floor.

The resident's plan of care indicated that two staff were to assist at all times and with all aspects of activities of daily living (ADL). The physiotherapist stated that resident was able to weight bear with the help of a two wheeled walker. The transfer directions, located in the resident's room, indicated two person side by side transfer with a walker.

PSW confirmed that they were the only staff member in the room, assisting with the transfer, and did not use the assistance of a walker.

Interim co-director of care (DOC) acknowledged that the staff member should not have attempted the transfer by themselves.

Failure to provide care as per the plan of care put the resident at risk of injury.

Sources: resident's clinical records; interviews with PSW and interim co-DOC and other staff.

[720920]

B) The licensee failed to ensure that the transfer direction for a resident was followed as outlined in the pan of care.

Rationale and Summary

Three PSWs stated that resident is a two-person pivot transfer.

Two PSWs confirmed that the transfer frame (a frame on the wall showing resident transfer status), in the room says sit to stand but they only use that direction when resident is having a bad day. They expressed that the resident does much better with two-person pivot transfer.

The Restorative coach confirmed that the resident's transfer status is two-person sara lift sit to stand and the direction is that Staff can go up a transfer, meaning providing more assistance, but staff cannot go down a transfer which is stepping down on transfer assistance.

The DOC stated that staff are expected to follow plan of care when providing care to residents.

Staff not following the safe transfer guidelines as per the plan of care and using an Improper transfer method could have resulted in the resident having a fall and sustaining an injury.

Sources:
Plan of Care (Transfer Frame, Care plan, Kardex)
Interview with PSWs, Restorative coach and DOC

[741771]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised when the resident's care needs changed, specifically regarding revising the resident's transfer information.

Rationale and Summary
A resident fell following a transfer. A physiotherapy/restorative referral was sent to reassess the resident's transfer ability to weight bear and ADL/mobility assistance. Following their assessment, both the physiotherapist and restorative coach determined that the resident required two people assist with transfers and staff were to use a wheelchair to transport the resident to the bathroom.

Prior to the fall, the resident’s plan of care indicated under the transfer focus that one person was to provide constant guidance and extensive physical assistance. The resident required two persons assist when they were fatigued. The Plan of care was not revised after the fall to include the results of the physiotherapist's reassessment of the resident's transfer requirements.

The interim co-DOC acknowledged that the resident's care plan should have been revised to reflect the change in transfer status.

Failure to revise the plan of care had the potential for the resident not to receive care in accordance with their needs.

Sources: resident's clinical records, observations; and interviews with the Interim Co-DOC, physiotherapist and other staff.

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WRITTEN NOTIFICATION: General Requirement for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the home's fall prevention and management program, required in Ontario Regulations (O. Reg.) 246/22 section (s) 53 (1), was evaluated and updated annually.

Rationale and Summary
O. Reg. 246/22 s. 53 (1), required long-term care homes to develop and implement an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's Elder Care Fall Prevention and Management document stated that the falls committee were responsible for completing the program's annual evaluation.

The interim co-director of care (DOC) provided an annual evaluation for 2021 and confirmed that the falls prevention and management program was not evaluated and/or updated in 2022.

Failure to evaluate the Fall Prevention and Management on an annual basis may have resulted in the program not reflecting changes in best practices or prevailing practices.

Sources: Elder Care Fall Prevention and Management (1-NR-70, December 20, 2021), 2021 Falls Program Evaluation; and interview with interim co-DOC.

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WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post fall assessment was conducted, using a clinically appropriate instrument that was specifically designed for falls.

Rationale and Summary
The home's Fall Prevention Program required that a post fall assessment be completed by registered staff after every fall using the home's Post Fall Assessment tool in Point Click Care (PCC).

When a resident fell, while being transferred to their wheelchair. A Post Fall Assessment was not completed, as acknowledged by interim co-DOC.

Failure to complete a post fall assessment may have led to a delay in the resident receiving treatment, the home's ability to identify possible contributing factors and implement a plan of action if needed.

Sources: resident's clinical records, Fall Prevention Program (1-NR-244, January 1, 2021); and interview with interim co-DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 109 (1)

The licensee has failed to ensure that a complaint alleging harm or risk of harm was forwarded to the Director as required under clause 26 (1) (c) of the Fixing Long-Term Care Act.

Rationale and Summary
A compliant was made to the DOC and the Executive Director about a resident's fall that had previously occurred. The complaint alleged harm or risk of harm to resident as a result of the fall.

The former DOC acknowledged receipt of the complaint and replied that a critical incident (CI) form would be sent to the Ministry of Long-Term Care (MLTC). They also stated that the complainant would receive a written response within 10 business days or be contacted if there were any unexpected delays.

A review of the CI system showed that a CI was not submitted to MLTC.

Failure to submit a complaint as per legislation may have resulted in the Substitute Decision Maker's (SDM) concerns being unaddressed in an appropriate manner.

Sources: email correspondence, CI system; and interview with interim co-DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed, no later than one business day, after an incident that caused injury to a resident which resulted in a significant change in their health condition.

Rationale and Summary
A resident had a fall resulting in pain in their right knee with flexion of the right hip. The resident was transferred to the hospital approximately five hours after the fall and the following day found to have a right hip fracture requiring surgery.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care after one business day after the home was made aware of the resident's hop fracture. The report indicated that the afterhours reporting line was not called regarding this incident.

Interim co-DOC acknowledged that the CI should have been submitted within one business day after the home was made aware of the resident's hip fracture.

Failure to send a CI within the required time frame may have resulted in the Director not being made aware of the situation and taking actions if necessary.

Sources: CI 2976-000076-22, resident's clinical records; and interview with interim co-DOC.

[720920]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall be compliant with O. Reg. 242/22, s.102 (2) (b).
Specifically, the licensee shall:
A) Ensure that residents on three units are encouraged or supported to perform hand hygiene either in their room or before entering the dining room prior to their meals.
B) Review the Hand Hygiene program with the Staff on three units and have Staff sign off on completion of the review.
C) Develop and implement an auditing process on three units for four weeks to ensure that residents are performing hand hygiene before meals.
D) A documented record of this auditing must be maintained in the home and should identify
i) the name of the person auditing,
ii) the date of the audit,
iii) actions taken if required.

Grounds

The licensee has failed to ensure that the Standard issued by the Director with respect to the IPAC is Implemented.

Rationale and Summary

Sanitizers and towelettes were available in the dining rooms. Six home areas were observed, and each home area had hand sanitizers and towelette dispensers mounted by the entrance to their dining room or on a table at the entrance into the dining room.

On an identified date, prior to the lunch meal, residents on the three different home areas were observed being assisted into the dining room but the residents did not wash their hands, nor did staff assist them with hand sanitizer or hand washing.

Two RPNs acknowledged that residents are expected to perform hand hygiene at meals times, before entering and when leaving the dining room.

A PSW said they were not aware that they were to assist residents with hand hygiene prior to meals.
IPAC Manger confirmed that Staff has been educated to wash residents' hands with alcohol hand rub and towelettes before entering and when exiting the dining room.

Not performing hand hygiene puts residents at risk of potentially acquiring or spreading infections, including COVID-19.

Sources:

Hand Hygiene Practices Policy # 1-IC-11
Observation of residents in the home areas
Interview with Staff

[741771]

This order must be complied with by March 1, 2023

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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/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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing

(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.