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

# Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

| **Date(s) of inspection/Date de l'inspection** | **Inspection No/ d'inspection** | **Type of Inspection/Genre d'inspection** |
|---|---|---|
| December 7, 8 & 9, 2010 | 2010_167_2976_07Dec102334 | Other Inspection related to a critical incident report # H-02471 |

**Licensee/Titulaire**

St. Joseph's Health System,

**Long-Term Care Home/Foyer de soins de longue durée**

St. Joseph's Lifecare Centre, 99 Wayne Gretzky Parkway, Brantford, Ontario N3S6T6

**Name of Inspector(s)/Nom de l'inspecteur(s)**

Marilyn Tone, Nursing Inspector # 167

## Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an other inspection related to a critical incident report submitted by the home.

During the course of the inspection, the inspector spoke with: The Administrator, The Director of Care the Acting Director of Care, the RAI Coordinator and a Registered Staff Nurse.

During the course of the inspection, the inspector: conducted a review of the health records for the identified resident and reviewed the home's policy and procedure related to Falls Prevention

The following Inspection Protocols were used during this inspection:
Personal Support Services Inspection Protocol
Critical Incident Reporting Inspection Protocol
Hospitalization and Death Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[3] WN

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

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| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s6(10)b
(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

**Findings:**

The plan of care for the identified resident was not updated to address care needs or risk factors after the resident's return form hospital.
1) The plan of care was not updated to identify the level of mobility allowed for the identified resident or how much assistance was required.
2) The plan of care was not updated to address the identified resident's level of pain or interventions to manage the pain.
3) The identified resident's plan of care did not address safety needs related to falls prevention after return from hospital.

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**WN #2**: The Licensee has failed to comply with LTCHA, 2007, O. Reg. 79/10 s.107 (1)2
Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

**Findings:**

The licensee home did not notify the Director immediately when a critical incident occurred as per legislative requirements for reporting.
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| **WN #3:** The Licensee has failed to comply with LTCHA, 2007, O. Reg. 79/10 s.107 (2)<br>(2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. | |
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| **Findings:**<br><br>The licensee did not notify the Director immediately when a critical incident occurred using the after hours pager as per the legislated requirements for reporting. | |
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| **Signature of Licensee or Representative of Licensee**<br>**Signature du Titulaire du représentant désigné** | | **Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**<br><br>Marilyn Tone |
|---|---|---|
| **Title:** | **Date:** | **Date of Report:** (if different from date(s) of inspection).<br><br>January 4, 2011 |