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

London District
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Original Public Report

Report Issue Date: July 21, 2023

Inspection Number: 2023-1459-0005

Inspection Type:
Critical Incident System

Licensee: St. Joseph's Health System

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

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.07.21 13:07:17 -04'00'

Additional Inspector(s)
Peter Hannaberg (721821)
Ali Nasser (523)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10, 11, 12, 13, 17, 2023.

The following intake(s) were inspected:
Intake: #00001290 - CI: 2976-000045-22 related to transferring and positioning techniques;
Intake: #00002636 - CI: 2976-000023-22 related to an unexpected death;
Intake: #00002748 - CI: 2976-000054-22 related to medication administration;
Intake: #00005700 - CI: 2976-000021-22 related responsive behaviours;
Intake: #00005787 - CI: 2976-000007-22 related to resident to resident physical abuse;
Intake: #00014345 - CI: 2976-000075-22 related to resident to resident emotional abuse;
Intake: #00015283 - CI: 2976-000080-22 related to the improper/incompetent care of multiple residents;
Intake: #00090311 - CI: 2976-000018-23 also related to falls prevention and management.

The following intake was completed as part of this inspection:
Intake: #00087613 - CI: 2976-000016-23 related to falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

The home submitted a Critical Incident System (CIS) report related to allegations of abuse.

A record review documented a specific intervention, which was no longer required by the resident.

Registered Practical Nurse (RPN) and Assistant Director of Care (ADOC) said the resident's care needs had changed and they no longer required the documented intervention. The plan of care was not revised to reflect this change and should have been.

ADOC said the plan of care would be revised and updated based on the current resident care needs. [523]

Date Remedy Implemented: July 13, 2023

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that had occurred in the home since the time of the last review.

Rational and Summary:
The home submitted a Critical Incident System (CIS) Report related to a medication incident and adverse drug reaction.

Assistant Director of Care (ADOC) said they were supposed to have their quarterly review in December 2022. It was not completed and should have been. The next quarterly meeting was scheduled in April 2023 and was completed.

Sources: Staff interview. [523]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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.

Rationale and Summary:
The home submitted a Critical Incident System (CIS) report related to improper treatment of a resident.

A clinical record review for the resident documented an intervention with specific direction for staff.

In an interview Director of Care (DOC) said the intervention provided specific directed for staff when caring for the resident. The intervention was not provided to the resident as specified in the plan, and this impacted the resident, increasing the risk of injury for both the resident and staff.

Sources: Clinical records and staff interviews. [523]

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the falls prevention and management program for more than one resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure their policy “Elder Care Fall Prevention and Management," as part of the licensee’s Falls Prevention and Management Program was complied with to reduce the risk of unidentified injury.

Rationale and Summary
A review of the residents’ clinical records documented that more than one resident experienced more than one fall. The home's policy states the registered nursing staff were to complete a head injury routine assessment, including the Glasgow Coma Scale. Further review of the clinical records showed there were no assessments completed as per the home’s policy. This increased the residents’ risk of unidentified injuries when neither resident had an assessment completed as per the home’s policy.

Sources: The home's investigation notes, the residents' clinical records, and an interview with Assistant Director of Care (ADOC). [721821]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that when more than one resident had a fall, they were assessed using a clinically appropriate assessment instrument.

Rationale and Summary
A review of the residents' clinical records documented more than one resident experienced a fall and post fall assessments were not completed for either resident. This increased the risk of unidentified injuries when the licensee failed to assess each resident after their fall.

Assistant Director of Care (ADOC) confirmed the residents had multiple falls, no assessments were completed, and should have been.

Sources: The residents' clinical records, the home's investigation notes, and an interview with ADOC. [721821]

WRITTEN NOTIFICATION: Altercations and other interactions between

residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)

The licensee has failed to ensure that when residents had an altercation, steps were taken to minimize the risk of further altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment.

The Ministry of Long-Term Care (MLTC) received a critical incident system (CIS) report related to an altercation.

A review of a resident's clinical records documented multiple demonstrations of altercations with no documented records of any interdisciplinary assessments. This impacted and increased the risk of potentially harmful interactions between residents, and staff when the residents' responsive behaviours were not assessed, triggers identified, and interventions implemented.

Assistant Director of Care (ADOC) said given the number of altercations the resident should have been assessed and an interdisciplinary team should have been involved with the resident's care and was not.

Sources: Resident clinical records, and interviews with staff, management and the external Behavioural Supports Ontario (BSO) team. [740]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (3) (b)

The licensee has failed to ensure that when a resident was restrained, the resident's condition was reassessed by a physician, a registered nurse in the extended class attending to the resident, or a member of the registered nursing staff only, at certain intervals, and at any other time when a reassessment was necessary based on the resident's condition or circumstances.

Rationale and Summary
A record review documented that a resident had several falls, and staff were concerned for the resident's safety. Due to staff identifying potential safety concerns, the staff decided to apply a restraint. Further review showed there was no documentation to support staff had monitored the resident at certain intervals, nor was there a reassessment of the resident's condition completed. This impacted the resident's safety and wellbeing, placing the resident at risk.

Assistant Director of Care (ADOC) said once the restraint was applied by staff, the resident should have been monitored and their condition reassessed.

Sources: The home's investigation notes, residents' clinical records, and an interview with ADOC. [721821]