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

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Original Public Report

Report Issue Date: September 26, 2023	
Inspection Number: 2023-1459-0006	
Inspection Type: Complaint Critical Incident	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Lifecare Centre, Brantford	
Lead Inspector Ali Nasser (523)	**Inspector Digital Signature** Ali Nasser Digitally signed by Ali Nasser Date: 2023.09.26 15:10:31 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 19, 21, 2023

The following intake(s) were inspected:

- Intake: #00093334 – Critical incident related to resident's fall.
- Intake: #00094654 – Complaint related to a resident's fall.

The following intake was completed in this inspection: Intake #00096305, related to a resident's fall.

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

Infection Prevention and Control
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 (1) (c)

The licensee has failed to ensure there was a written plan of care for a resident that set out a clear direction to staff and others who provide direct care to the resident.

Summary and Rationale
A clinical record review for a resident showed risk for falls plan of care interventions that provided two different level of falls' risk.

In an interview the Assistant Director of Care (ADOC) said the care plan did not provide clear direction to staff as the plan of care provided two different levels of fall's risk. ADOC confirmed the resident was receiving the correct falls prevention interventions.

There was a risk to the resident related to not having clear direction to staff who provide direct care to the resident.

Sources: Clinical record review and staff interviews. [523]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee had failed to ensure that the care set out in the plan of care was based on the needs of a resident.

Summary and Rationale
During interviews multiple staff members confirmed the resident's need for a specific intervention. Staff said the intervention had helped in reducing the number of falls for the resident.

A clinical record review showed documentation that the intervention was being used and it had helped decrease the resident's number of falls.

A review of the plan of care showed no direction to staff to implement this specific intervention.

In an interview the ADOC confirmed there was no direction for staff to implement this specific intervention. The plan of care was not based on the needs of the resident.

There was a risk to the resident as the plan of care was not based on the needs of the resident.

Sources: Clinical record review and staff interviews. [523]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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 home's falls prevention and management program policy related to fall risk assessment, included in the required falls prevention program in the home, for the resident.
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies, procedures and protocols for the falls prevention program were complied with. Specifically, staff did not comply with the licensee's "Fall Prevention Program" policy, with a revision date of December 20, 2021.

Summary and Rationale
A clinical record review for the resident showed the resident had two fall risk assessment done post falls that were not fully completed.

The home's policy titled "Falls Prevention Program" last revised December 20, 2021, stated "The Fall Risk Assessment is to be completed by Registered Nursing Staff after every fall".

In an interview the ADOC said the procedure was for the Registered staff to fully complete all sections of the fall risk assessment as it may impact the outcome score indicating the fall risk level of the resident.

There was a risk to the resident by not fully completing the fall risk assessment of the resident.

Sources: Clinical record review and staff interviews. [523]