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: August 6, 2024
Inspection Number: 2024-1459-0004
Inspection Type: Complaint
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Lifecare Centre, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 30, 31, 2024 and August 1, 2024

The following intake(s) were inspected:

- Intake: #00116669, complaint related to resident care concerns.

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

Resident Care and Support Services
Infection Prevention and Control

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)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure resident's plan of care had clear directions to staff and others who provided direct care to the resident.

Rational and Summary:
The Ministry of Long-Term Care received a complaint related to resident's care concerns.

A clinical record review for the resident and staff interviews showed the plan of care did not have clear direction on the type of continence care product to be used for the resident.

In interviews two Clinical Managers reviewed the resident's clinical records and said the plan of care was not providing clear direction to staff on the type of continence care product to be used and they will ensure the plan of care was providing clear to direction to staff on what type of product to be used.

The resident was put at risk when staff did not have clear direction of what type of incontinent product was to be used.

Sources: Clinical record reviews and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee had failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rational and Summary:

The Ministry of Long-Term Care received a complaint related to resident's care concerns. The complainant said the resident's plan of care was changed without their knowledge.

A clinical record review for the resident and review of a concern form completed by a Registered Nurse confirmed that the plan of care for the resident was changed specific to the type of continence care product being used without the SDM's knowledge.

In interviews two Clinical Managers confirmed the plan of care was changed without discussion with or informing the SDM. They said the SDM should have given an opportunity to participate in the development and implementation of the resident's plan of care. Clinical Managers held a meeting at the time of inspection with the SDM and updated the care plan with their participation.

There was a risk to the resident when their plan of care was changed without

providing them or their SDM with an opportunity to develop or implement the plan of care.
Sources: record reviews and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provisions of the care set out in the plan of care were documented:

Rational and Summary:
A clinical record review for the resident and staff interview showed two specific treatments that required weekly documentation in the progress notes were not completed as per the plan of care.

In interviews two Clinical Managers confirmed the treatments were not documented in the progress notes as required. They said the expectation was for the provisions of care set out in the plan of care to be documented.
Sources: record reviews and staff interviews.