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: December 23, 2024
Inspection Number: 2024-1459-0007
Inspection Type: Proactive Compliance Inspection
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): November 14, 15, 18, 19, 21, 22, 25, 26, 27, 28, 29, 2024
The inspection occurred offsite on the following date(s): November 20, 27, 2024 and December 2, 3, 2024
The following intake(s) were inspected:

- Intake: #00131186 - Proactive Compliance Inspection - 2024

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Palliative Care
Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices

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)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

Rationale and Summary
During the Initial tour of the home, the policy to promote zero tolerance of abuse and neglect of residents was not posted in a conspicuous and easily accessible location. The Administrator stated the policy was posted for staff behind a locked door near the tuck shop. The abuse policy was observed in a binder behind a locked

door accessible to staff only. The abuse policy was then posted to the Family Information Board on the main level of the home near the main elevators.

Sources: Observations and staff interviews.

Date Remedy Implemented: November 26, 2024
NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The licensee failed to ensure that the long-term care home's explanation of whistle-blowing protection was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

Rationale and Summary
During the Initial tour of the home, the policy to promote zero tolerance of abuse and neglect of residents was not posted in a conspicuous and easily accessible location. The Administrator stated whistle-blowing protection was documented as part of the abuse policy and was posted for staff behind a locked door near the tuck shop. The abuse policy was observed in a binder behind a locked door accessible to staff only. The abuse policy was then posted to the Family Information Board on the main level of the home near the main elevators.

Sources: Observations and staff interviews.

Date Remedy Implemented: November 26, 2024
NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee failed to ensure that the information required to be posted in the home and communicated to residents included the current version of the visitor policy.

Rationale and Summary
During the Initial tour of the home, the current version of the visitor policy was not posted in a conspicuous and easily accessible location. The Administrator verified the current visitor policy was to be posted and stated the visitor policy would be posted to the Family Information Board on the main level of the home near the main elevators. The Visitor Policy was observed posted.

Sources: Observations and staff interviews.
Date Remedy Implemented: November 26, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

3. Every resident has the right to have their participation in decision-making respected.

The licensee has failed to ensure that a resident's right to have their participation in decision-making was respected.

Rationale and Summary
Health Records indicated that a resident was having their pain assessed using the Pain Assessment In Advanced Dementia Scales (PAINAD) and no other pain assessments were completed.

The resident was able to clearly converse with the inspector, articulating details about themselves and their pain. A Registered Nursing Staff stated that the resident was usually able to adequately articulate and verbalize their pain and that a numerical pain scale should have been used to assess the severity of the resident's pain, obtaining that information from the resident and not a PAINAD, as well as other information including location, type, etc.

The resident was not afforded the right to participate verbally in their pain assessment and subsequent decision making, when a PAINAD was used..

Sources: resident health records, resident and staff interviews

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was reported to the Director when a staff member reported a suspect staff to resident abuse incident.

Rationale and Summary
During an interview a staff member informed of an incident, when they had observed suspect staff to resident abuse. The staff member informed that they had immediately reported the incident and later had a meeting with Human Resources (HR) regarding the incident.

The HR Manager and the Director of Care (DOC) were unable to find any documentation related to the incident noted by the staff member. When searching in the Critical Incident System, no results were found related to the identified staff or resident.

When an incident of suspected resident abuse was not immediately reported to the Director, the incident could not be addressed appropriately by an inspector to ensure compliance with the requirements under the Act.

Sources: Resident and staff interviews, resident health records.

WRITTEN NOTIFICATION: Duty to Respond

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 63 (3)

Powers of Residents' Council

s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to ensure that if the Residents' Council had advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Rationale and Summary

The Residents' Council Meeting Minutes documented multiple concerns between a range of dates.

The Residents' Council Liaison verified it was their role to assist residents to run their council meetings, document meeting minutes and get answers to their questions that would to be directed to the appropriate department or individual. The Liaison verified there were multiple concerns identified at council meetings, and there was no response in writing to Residents' Council within 10 days of receiving the concern.

The Vice President of Residents' Council verified the council's liaison typed the meeting minutes and would follow up with concerns with management and the response was to be received within 10 days, but that the response was not in writing. There was no documented record within 10 days of the response to concerns communicated at Residents' Council.

Sources: Residents' Council Meeting Minutes, Residents' Council President and Vice

President interview and staff interviews.

WRITTEN NOTIFICATION: Duty to Respond

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 66 (3)

Powers of Family Council

s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee failed to ensure that if the Family Council had advised the licensee of concerns or recommendations, the licensee shall within 10 days of receiving the advice, respond to the Family Council in writing.

Rationale and Summary

The Family Council Meeting Minutes documented multiple concerns across various monthly meetings, meeting minutes for the subsequent months were noted to contain the follow up from prior concerns.

The Family Council Liaison verified it was their role to communicate the councils' concerns, complaints or compliments to the most appropriate department and/or individual, they would then respond in writing by email to the secretary of Family Council within 10 business days of receiving the concern. The secretary would then add the responses to the meeting minutes. The Family Council Liaison verified their response in writing to Family Council surpassed 10 days for a range of monthly meetings, as not all individuals who received concerns addressed them in the allotted time.

Sources: Family Council Meeting Minutes, Family Council Chair interview and staff

interviews.

WRITTEN NOTIFICATION: Air Temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured under O. Reg. 246/22 s. 24 (2) was documented once every evening or night.

Rationale and Summary
Measuring and documentation of air temperatures during the evening or night was to be completed by night shift nursing staff. Temperature logs for a range of dates included 24 out of 154 dates in which temperatures were documented during that time period. It is unknown if temperatures were monitored at all during the evening or night prior to this date range. Monitoring and documentation of air temperatures during the day shift was to be completed by housekeeping staff on each unit. Several weeks of logs were missing, as well as a number of days with no documentation. One housekeeper had documented the temperature in the soiled utility room and stated that they don't measure the temperature in the dining room because it usually ran approximately five degrees higher than the rest of the unit. The Environmental Services Manager indicated they reviewed the documentation to ensure it was completed and there were no temperatures out of range requiring follow up.

There was no direction in the nursing staff evening and night job routines related to

air temperatures. There was no process in the home to check or ensure the temperatures were being monitored and documented on evening or night shift. The home did not have an air temperature policy and the home's heat related illness policy indicated that housekeepers would monitor and document temperatures, but didn't indicate when, where, or what to do if the temperatures were not within a safe or comfortable range. The policy also provided general guidance related to heat related illness that was not applicable to long term care or residents. There was risk that air temperatures were not within a safe or comfortable range for residents during the evenings and nights when they were not monitored.

Sources: Air temperature documentation records, registered nursing staff evening and night job routines, the home's heat related illness policy, and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident, who had significant pressure injuries, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Sources: Health records for resident and staff interview.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the home's nutrition/hydration assessment and risk policy was complied with.

The Fixing Long Term Care Act, 2021 s. 15 (1) (a) states: Every licensee of a long-term care home shall ensure that there is an organized program of nutritional care and dietary services for the home to meet the daily nutrition needs of the residents.

Ontario Regulation 246/22 s. 74 states: The organized program of nutritional care and dietary services required under clause 15 (1) (a) of the Act shall include, the identification of any risks related to nutritional care and dietary services and hydration and the implementation of interventions to mitigate and manage those risks.

Ontario Regulation 246/22 s. 11 (1) (b) states: Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

The home's Nutrition/Hydration Assessment & Risk policy stated: All residents will be assessed for nutrition/hydration risk on admission, upon return from hospital, and according to the RAI-MDS process. Residents will be assessed at either high, moderate or low nutrition/hydration risk based on the nutrition/hydration assessment and the risk indicators.

Rationale and Summary
A resident at their time of admission had a nutritional assessment completed, but it did not include the identification of the resident's nutritional risk. Progress notes indicated the resident had multiple other health concerns which contributed to nutritional risk. Over three months after admission, the resident was first identified as being high nutritional risk.

The Registered Dietitian (RD) said that they started working in the home recently and were aware that there were residents who haven't had a nutritional assessment since 2023. They said that they and the other RD were working in the quarterly Minimum Data Set (MDS) schedule to get the nutritional risk assessments completed for everyone, as well as respond to all of the dietary referrals.

When the resident's nutritional risk was not identified until over three months after they were admitted as per policy, there was risk that they did not receive the nutritional interventions or follow up needed to manage their nutritional needs.

Sources: Resident health records, the home's Nutrition/Hydration Assessment & Risk policy last revised March 1, 2022, and interview with the Registered Dietitian.

WRITTEN NOTIFICATION: Dining and snack service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that three residents who required assistance with eating were not served a meal until someone was available to provide the assistance required by those residents.

Rationale and Summary
A direct care staff was observed assisting two different residents, at the same table with their meals.

A different resident, who also required assistance was observed at a different table with their meal in front of them with no one assisting them. The staff member requested assistance from their colleagues on two separate occasions, the staff member was then seen simultaneously assisting all three residents with their meals until another staff member arrived to assist.

The same direct care staff member was later observed to offer and distribute the desserts to residents throughout the dining room, which had resulted in residents they had been assisting, being served their dessert before someone was available to assist them.

In interview, the direct care staff confirmed that these events had occurred and voiced concerns that they did not have enough staff assistance in the dining rooms to assist residents adequately and safely during the meal service.

Sources: Dining observation, staff interview

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 80 (2)

Registered dietitian

s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a Registered Dietitian (RD) was a member of the staff of the home who was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary

In interview with the Nutrition Services Manager, they advised that the long-term care home was attempting to hire a new RD. However, they currently had one RD temporarily working, as well as a secondary RD who was only working remotely.

In review of the hours of work for the month of November 2024, for the RD who had been working onsite, the document demonstrated 85 hours of work.

The Operations Manager confirmed that that St. Joseph's Life Care Centre was a 205-bed home.

205 residents x 30 minutes = 102.5 hours per month, therefore the onsite RD hours were 17.5 hours less than the required amount of 102.5 hours.

There was a risk that the clinical and nutritional needs of the residents would not be

met when the RD was not onsite in the home for a minimum of 30 minutes per resident, per month.

Sources: RD hours, staff interviews.

WRITTEN NOTIFICATION: Dealing with complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1)

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

ii. an explanation of,

A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure a verbal complaint made by a resident concerning their care was dealt with as provided for in the Regulations.

Rationale and Summary
In interview with a resident, they expressed concerns related to care they had received on a specific date.

The Director of Care (DOC) informed were aware of the incident and followed up by speaking with the staff involved and the resident's Power of Attorney (POA).

There was a risk that the resident care concerns were not adequately addressed when the complaints procedure provided for in the Regulations was not followed.

Sources: Staff and resident interviews, resident progress notes.

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management

system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
The most recent Medication Management Committee meeting for the quarterly evaluation of the medication management system was March 6 and June 12, 2024, and the Administrator was absent.

The home did not meet at least quarterly to evaluate the effectiveness of the medication management system to recommend any changes necessary to improve the system for April - June 2023, July - September 2023, and April - June 2023.

The Director of Care verified there had been no meeting since June 12, 2024. The medication management system was not evaluated since Quarter one January to March 2024. The Medication Management Committee did not identify patterns and trends and did not take appropriate actions to improve the medication management system.

Sources: Medication Management Committee meeting minutes, CareRx reports and staff interviews.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.

Drug destruction and disposal

s. 148 (2) The drug destruction and disposal policy must also provide for the following:

2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a drug destruction and disposal policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 246/22 s. 11 (1) (b) states: Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

Ontario Regulation 246/22, s. 148 (2) 2 states, the drug destruction and disposal policy must also provide for any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Rationale and Summary

The drug storage for controlled substances for destruction in a home care area was located in the medication room. There was a drug "drop slot" for controlled substances for destruction. The controlled drugs that were to be destroyed and

disposed of were not stored safely and securely in the "drop slot" storage area within the locked med room until the destruction and disposal occurred. The Inspector was able to remove multiple cards and ampules of controlled substances from the drop slot with ease. Registered Nursing staff verified the storage area was too full and needed to be emptied. A sign was posted on the cupboard door that documented, "If you have an item that will not fit through the slot, please contact the DOC and they will place it in the cupboard."

The Director of Care (DOC) verified there was no other cupboard for storage and that registered staff would call their Clinical Manager to report the overflow. A Clinical Manager verified that the Clinical Managers and the Clinical Pharmacist were the team acting together to destroy controlled substances and the registered staff would contact the Clinical Managers to report the overflow. The DOC stated the registered staff did not secure the controlled substances for destruction and did not notify the Clinical Manager when the storage area was full.

The CareRX Destruction and Disposal of Narcotic and Controlled Medications Policy, documented the home was to ensure that all narcotic and controlled medications were securely stored and double locked until they are destroyed. "If a narcotic or controlled medication for destruction does not fit in the "drop-slot" of the one-way access disposal box notify the DOC or designate to open the box and insert the bottle into the box for secure storage in preparation for destruction.

Controlled substances to be destroyed and disposed of shall be stored in a double-locked storage area within the home, even though the medication door was locked and the destruction storage area was locked, the drug storage area was compromised when the registered staff continued to deposit controlled substances into the "drop slot" for a storage area that was already full. The drugs for destruction were not stored safely and securely until the destruction occurred.

Sources: policy review, observations and staff interviews.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the report for the Continuous Quality Improvement (CQI) initiative for the home contained how, and the dates when, the results of the survey taken were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary
The St. Joseph's Lifecare Centre Quality Improvement 2023-24: A Year in Review report was the report for the continuous quality improvement initiative. The report did not document how the results of the satisfaction survey were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home or when.

Residents' Council Meeting Minutes documented the Resident Satisfaction Survey and Family Satisfaction Survey results were shared by the Administrator. Family

Council Meeting Minutes documented survey results were shared.

The Manager of Quality, Innovation and Learning who was also the CQI lead in the home verified the results of the survey were also shared with Family Council. The CQI lead stated the annual CQI report did not include how the results of the satisfaction survey were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home or when.

Sources: CQI report, satisfaction survey documentation and staff interviews.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,

iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the report for the Continuous Quality Improvement (CQI) initiative for the home contained the required information for Ontario Regulation 246/22, s. 168 (2) 6.

Rationale and Summary
The St. Joseph's Lifecare Centre Quality Improvement 2023-24: A Year in Review was the report for the continuous quality improvement initiative. The report did document the actions taken to improve the long-term care home based on the documentation of the results of the survey taken, however lacked the documentation related to the dates the actions were implemented and the outcomes of the actions. The role of the Residents' Council and Family Council in actions taken, the role of the CQI committee in actions taken and how, and the dates when the actions taken were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home was missing from the report.

The Manager of Quality, Innovation and Learning who was also the CQI lead in the home verified the information was not documented as part of the CQI report.

Sources: CQI report, satisfaction survey documentation and staff interviews.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the Continuous Quality Improvement (CQI) initiative report was provided to the Residents' Council and Family Council.

Rationale and Summary
The Family Council and Residents' Council Meeting Minutes between November 2023 - October 2024, did not have documentation that the CQI report was provided to either council.

The Manager of Quality, Innovation and Learning who was also the CQI lead in the home verified the CQI report was deliberated at the CQI Committee which had representation of the Residents' and Family Council members, however the report was not provided to Residents' or Family Councils.

Sources: Family Council and Residents' Council Meeting Minutes, and interviews.

COMPLIANCE ORDER CO #001 Plan of care

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

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

The Licensee has failed to comply with FLTCA, 2021 s. 6 (2).

Specifically, the licensee must:

a) Ensure three specific residents have a documented assessment related to the need for the use of footrests.

b) Ensure the three residents plans of care include clear direction related to the residents' use of footrests.

c) Ensure that any changes in the plans of care for the three residents, related to the use of footrests is communicated to the applicable staff. Ensure the communication is documented including the date it was communicated, method and content of the communication and who provided it.

d) Conduct a weekly audit of observations of the three residents, related to the use of footrests to ensure that footrests are being utilized appropriately as per their individual plan of care. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of three residents, and on their needs and preferences.

Rationale and Summary

Three different residents, on three separate occasions were observed being pushed in a wheelchair without footrests by a staff member. For each of the three residents, there were no assessments and no direction in their plans of care related to the use of footrests. There was a risk of injury to these residents when they were pushed in a

wheelchair without footrest in use.

Sources: Resident health records, observations of residents and staff interviews.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #002 Plan of care

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) The Director of Care or designate will conduct an audit at minimum twice weekly, during a meal period to ensure that a specific resident receives the assistance they require related to meals, audits will continue until an Inspector has complied the order
B) A documented record will be maintained, including the dates the audits were conducted, the name of the individual completing the audit, what was observed during the audit, and any corrective actions taken as a result

Grounds
The licensee has failed to ensure that a resident was provided with the care set out in their plan of care, when they were assisted with a specific care activity by one staff.

Rationale and Summary
In interview, the resident expressed concerns that a staff member had assisted

them with a care activity as a one staff assistance. The resident's care plan stated that they required assistance of two staff for that provision of care.

There was a risk of injury to the resident when they were assisted with care using a one staff assist, as the resident and their care plan indicated they required two staff.

Sources: Resident and staff interview, resident care plan

The licensee has failed to ensure that the care related to eating assistance that was set out in the plan of care, was provided to a resident as specified in the plan.

Rationale and Summary

The inspector observed a resident alone, and unattended, with an untouched full meal tray in front of them. A direct care staff said that the resident required assistance with feeding, and it was not safe for food to be left in front of the them while they were alone.

The resident's care plan related to eating, outlined the times and circumstances in which the resident required assistance with feeding. The resident was at risk for choking when given a meal while alone, with no staff assistance.

Sources: Observations of the resident, review of resident health records, staff interviews

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #003 Doors in a home

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 12 (1) 2.
Specifically, the licensee must:
a) Ensure all doors leading to secure outside patio and balcony areas that preclude exit by a resident are equipped with locks to restrict unsupervised access to those areas by residents.
b) Ensure the home reviews and/or revises their policies related to door and balcony security including updating the legislative references to align with the FLTCA, 2021. A written record of the review, date, attendees, and an outline of the revisions made will be maintained.

Grounds
The licensee failed to ensure all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

Rationale and Summary
During an initial tour of the home, an unlocked patio door was observed on a unit in a home care area. The patio door leading to the outside patio/balcony area was unlocked with a piece of wood blocking the bottom track to open the door, but it was easily removed and there was no locking mechanism that was functional. The

key lock device affixed to the top of the inside slider door frame and was not engaged or locked to prevent opening and appeared in disrepair. A different home care area with a patio door leading to the outside patio/balcony area was unlocked and there was no locking mechanism that was functional and the key lock device affixed to the top of the inside slider door frame appeared in disrepair.

The Resident Balcony Secured Area policy documented each resident home area balcony would have a locking system that required a staff person to unlock and lock the access door.

At the time of the inspection the management staff, registered staff and recreation staff were unaware that the patio doors leading to an outside secured patio/balcony were unlocked and in disrepair. The implementation of a security check for the patio doors were incomplete for several weeks and no one knew how long the doors were in disrepair. The door was accessible by residents using the recreation room.

Sources: observations, policy review and staff interviews.

This order must be complied with by January 17, 2025

COMPLIANCE ORDER CO #004 Skin and wound care

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection

(2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with Ontario Regulation 246/22, s. 55 (2)(b)(iv).
Specifically, the licensee must:
a) Ensure two specific residents wounds and areas of altered skin integrity are assessed weekly and any other time as needed.
b) Based on the weekly assessments, ensure the two residents receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.
c) Based on the weekly assessments, ensure plans of care for the two residents provide up to date clear direction related to skin and wound care.
d) Provide training to all registered nursing staff on the expectations in the home for completing weekly skin and wound assessments and the documentation required. A documented record must be maintained of this training, including the date the training was provided, content covered as part of the training, who provided the training, and who attended the training.
e) Conduct a weekly audit of the two resident's plans of care, treatment administration records and assessments, to ensure the assessments are completed and documented. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector.

Grounds
The licensee has failed to ensure that areas of altered skin integrity were reassessed weekly for two residents.

Rationale and Summary
Two separate residents were identified as each having multiple areas of altered skin integrity. In a review of documentation in PointClickCare (PCC) for the two residents, many inconsistent, incomplete, and missed skin and wound assessments were identified over the span of several months.

A Registered Nursing Staff said that they have not had training related to the PCC skin and wound application used for completing weekly wound assessments, that they didn't feel very comfortable using it and wanted training. A Clinical Manager said that the expectation was that wounds were reassessed weekly using the skin and wound app in PCC, and that directions in the Treatment Administration Records (TARS) were not clear. They said have identified gaps in the home with weekly wound assessments not being completed, and that it was concerning that staff were signing in the TAR that they were completed when they were not. They said they were working on these gaps with the registered staff in the home. Both of the resident's had wounds that worsened during the time period when weekly wound assessments were not being completed.

Sources: Resident health records, Skin and Wound Program policies, and staff interviews.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #005 Pain management

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with Ontario Regulation 246/22, s. 57 (2).

Specifically, the licensee must:

a) Ensure two specific residents receive comprehensive pain assessments using a clinically appropriate assessment tool when the residents' pain is not relieved by initial strategies.

b) Ensure the two residents plans of care are based on their comprehensive pain assessments and include clear direction related to the resident's pain and interventions that are inclusive of pharmacological and non-pharmacological interventions related to pain.

c) Review the home's policies related to pain assessment and pain management. Revise the policies and pain assessment tools as necessary. Keep a record of this review, the date, who participated, the results of the review and any changes made. If any changes to the policies or assessment tools are made, ensure that all applicable staff are made aware of the changes and keep a record of the communication, the date, how it was sent and by whom.

d) Conduct a weekly audit related to pain management, of the two residents pain assessments and plans of care, to ensure that comprehensive pain assessments are completed, and the plans of care updated as needed to effectively manage the residents' pain. A documented record must be maintained of this audit, including the date the audit was completed, who completed the audit, the name of the resident the audit was completed for, any concerns identified, and the corrective action taken as a result of the audit. The auditing process must continue until the Compliance Order has been complied by an inspector

Grounds

The licensee has failed to ensure that when pain for two separate residents was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A. In a record review, a resident received as needed (PRN) breakthrough pain medication on multiple occasions There was no assessment of the resident's pain that included the type, location, frequency of pain or what helped or made their pain worse, as well as, no assessment of non-pharmacological interventions for pain management on or around the time when the breakthrough medication was provided.

On a specific date, a Pain Assessment in Advanced Dementia Scale (PAINAD) was completed for resident that indicated they were in pain. However. there was no comprehensive assessment of the resident's pain that included the type, location, frequency of pain or what helped or made their pain worse, as well as, no assessment of non-pharmacological interventions for pain management on this date and no as needed pain medication was provided on that date. A PAINAD was also completed on another occasion, indicating the resident had pain with no further assessment completed.

B. A resident at the time of their admission had a Pain Assessment in Advanced Dementia Scale (PAINAD) completed, which indicated the resident had pain.

The resident had been receiving a breakthrough medication for pain, which the documentation indicated that it was ineffective. There was no assessment of the resident's pain that included the type, location, or frequency of pain or what helped or made their pain worse, as well as, no assessment of non-pharmacological

interventions for pain management on or around the time when the resident received breakthrough pain medication.

A Clinical manager stated that the home did not have a comprehensive pain assessment tool, the only pain assessment tools the home used were the PAINAD and Fraser numerical pain scale, with both measuring severity only, they did not assess type, location or any other indications related to pain. Each of these residents had pain that was not relieved by initial interventions, and a comprehensive pain assessment was not completed and no further actions taken.

Sources: Health records for residents, pain program, and staff interviews.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #006 Dining and snack service

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

A) Review and revise their Food Temperature policy to include an upper limit for hot foods and fluids, outlining a temperature at which food will not be served to

residents and the steps that staff will take in the event a food or fluid item has exceeded the limit

B) Train Food Service Workers and any other staff responsible for measuring food and fluid temperatures on the revised policy, as well as the expectations for measuring the temperatures of food and fluids. A documented record will be maintained of the training including the dates the training occurred, names of staff who attended, and the information that was trained on.

Grounds

The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents, when food temperatures were not completed, and the long-term care home's Food Temperature policy did not include an upper limit to advise when it is unsafe to serve food that is too hot.

Rationale and Summary

When food temperature logs were requested for a lunch service on a home area, A Dietary Aid provided these and informed that they had missed taking some temperatures. Upon review of the document, there were no recorded temperatures for eight different food items.

In interview with the Nutrition Services Manager, they confirmed that measuring food temperatures was how the home ensured that food was served at a temperature that was safe and palatable, and that recording temperatures prior to serving was an expectation for each food item and texture.

Additionally, in interview when the Dietary Aid was asked what temperature was too hot to serve to residents, and what would be done in that circumstance, they advised that this had never been an issue and cold not articulate a response as to

what would be done.

In review of the Food Temperature Policy, this informed that hot foods must reach a temperature of sixty degrees Celsius before going into the steam table, and if not at the proper temperature must be reheated to an internal temperature of 74 degrees Celsius because serving. However, the policy did not provide for an upper limit describing when food or fluids would be too hot to serve, and steps to take in that event.

The temperature log, also contained a note at the bottom stating appropriate temperature for hot holding was sixty degrees Celsius or above.

There was a risk of injury to residents when there was not an established process in place to implement and consistently ensure that food and fluids are served at a temperature that was safe and palatable.

Sources: Food Temperature Policy, food temperature logs, staff interviews

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #007 Medication Incidents and Adverse Drug Reactions

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (3)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe

hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,

(i) reduce and prevent medication incidents and adverse drug reactions,

(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and

(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;

(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 66/23, s. 30.

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

The Licensee has failed to comply with O. Reg. 246/22, s. 147 (3).

Specifically, the licensee must:

a) Ensure the home evaluates all medication incidents that have occurred since April 1, 2024, including incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review of the January to March 2023 incidents.

b) Ensure there is a documented record of the review including strategies to reduce and prevent medication incidents and adverse drug reactions, improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with

evidence-based practices and to identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia.

c) Ensure any changes and improvements identified are documented as part of the evaluation, including who was responsible for the implementation, how the changes and improvements were implemented with dates and outcomes identified.

Grounds

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents that had occurred in the home since the time of the last review.

Rationale and Summary
The Medication Management Committee meeting for the quarterly evaluation of the medication management system included the quarterly review of all medication incidents. The home did not meet at least quarterly to evaluate all medication incidents between April - June 2023, July - September 2023, and April - June 2023.

The home did not complete a quarterly review of all medication incidents that have occurred in the home since the time of the last review. The opportunity to reduce and prevent medication incidents and adverse drug reactions by implementing actions required, possible changes and improvements was missed to prevent risk and harm to residents.

The Director of Care (DOC) verified the information collected as part of the CareRx Medication Incident Analysis report was reviewed at the Medication Management Committee meetings. The DOC stated there would be a written record of the actions taken to reduce and prevent medication incidents and adverse drug reactions and a discussion of incidents involving high risk medications. However, after the January to March 2024 review of medication incidents at a Medication Management Committee meeting, there was no other analysis or review to determine

improvements to be implemented to reduce and prevent medication incidents between April and September 2024.

Sources: Medication Management Committee meeting minutes, CareRx reports and staff interviews.

This order must be complied with by January 31, 2025

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

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.