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: March 07, 2024
Inspection Number: 2024-1459-0001
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	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.03.11 14:09:26 -04'00'

Additional Inspector(s) Samantha Perry (740)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26, 27, 28, 29, 2024.

Inspector Stephanie Newton (#000820) was also present during the inspection.

The following intake(s) were inspected:

- Intake: #00100530, related to alleged staff to resident abuse.
- Intake: #00105683, related to a resident's fall.
- Intake: #00108816, related to a resident's fall.
- Intake: #00109390, Complaint related to alleged resident abuse.
- Intake: #00109476, related to alleged resident to resident abuse.
- Intake: #00109771, related to an outbreak in the home.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
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 (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 licensee has failed to ensure that the care set out in a resident's plan of care was based on the resident's needs and preferences.

Rationale and summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to care concerns for a resident.

A clinical record review of the resident showed progress notes where the resident expressed specific care preference. Furthermore, there was no documentation in the resident's plan of care to include their specific preference. On a certain date the

resident was impacted and at actual risk of receiving care that was not based on their needs and preferences.

The Director of Care (DOC) said the resident's specific need and preference was not documented as part of the resident's care plan and should have been to ensure the information was also in the Kardex to accurately direct staff and further ensure the resident's plan of care was based on their needs and preferences.

Sources: clinical records and interviews with staff and management. [740]

WRITTEN NOTIFICATION: Reports of investigation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to report to the Director the investigation results for an incident of alleged abuse of a resident and every action taken in response to the incident.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report related to allegations of staff to resident physical abuse.

A review of the internal investigation notes and interview with the DOC showed the investigation was completed but the CIS was not updated with the results of the investigation and action taken in response to the incident. The DOC said the

expectation was for the CIS to be amended with that information.

Sources: internal investigation notes and staff interview. [523]

WRITTEN NOTIFICATION: Immediate Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

FLTCA s. 28 (1)
The licensee has failed to ensure when a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Rational and Summary:
A clinical record review and staff interviews showed that on a certain date an incident of improper or incompetent treatment or care of the resident had occurred.

The home did not immediately report the incident to the Director.

In an interview the DOC said they were made aware of the incident and confirmed that the incident was an improper or incompetent treatment or care of the resident that put them at risk of harm. They the incident was called in to the afterhours line and they were surprised when they found out it was not completed.

The DOC said the expectation was for any allegations of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident should be reported to the Director.

There was minimal risk to the resident with the incident not reported immediately.

Sources: clinical record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used a specific equipment for the resident in accordance with the manufacturers' instructions.

Rational and Summary:
A clinical record review and staff interviews showed that on a certain date an incident of improper or incompetent treatment or care of the resident had occurred while using a specific equipment.

In an interview inspector reviewed with the ADOC the manufacturer's instructions for the specific equipment. The ADOC said the staff did not use the equipment in accordance with manufacturers' instructions which put the resident at risk.

Sources: clinical record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours the developed strategies were implemented to respond to their behaviours.

Rationale and summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to resident care concerns.

A clinical record review for the resident supported the resident had been demonstrating escalating behaviours for an extended period of time. The records also showed no record of a referral to the Behavioural Supports Ontario (BSO) program as part of the home's interdisciplinary strategies to assess and meet the resident's care needs related to their escalating behaviours.

Additionally, the resident's plan of care documented certain direction for staff to follow when the resident was demonstrating responsive behaviours. On a certain date the resident was demonstrating responsive behaviours. The staff did not

implement the documented strategies, resulting in an actual impact and risk to the resident.

A RPN said the resident's behaviours had been escalating and that staff were becoming frustrated, and therefore, the involvement of the interdisciplinary team, including the BSO program should have been sought.

The DOC said staff should have responded to the resident's responsive behaviours by implementing the strategies developed as part of the resident's plan of care, and a re-referral to the BSO program should have been completed to ensure the resident's escalating behaviours and care needs were being met by the interdisciplinary team.

Sources: Resident's clinical record review, and staff interviews. [740]

WRITTEN NOTIFICATION: IPAC

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program specifically, enhanced masking measures.

Rationale and summary:

The Ministry of Long-Term Care (MLTC) received a critical incident system (CIS) report related to St. Joseph's Lifecare Centre's infectious disease outbreaks.

During a tour of the home multiple staff members were observed in resident care areas and in home areas that were in an active infectious disease outbreak, wearing their masks below their chins, therefore, the masks were not covering their mouths or noses.

The staff members both said they were aware of the MLTC enhanced masking requirements and the home's IPAC program guidelines which documented staff must wear their masks covering their mouths and noses when working in the Long-Term Care Home (LTCH).

The IPAC lead said it was their expectation that all staff wore their masks appropriately covering their mouths and noses at all times, except for breaks, when they were working at the LTCH.

Sources: Observations, interviews with staff and management, MLTC IPAC enhanced measures and the home's IPAC program. [740]