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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 31, 2024
Inspection Number: 2024-1459-0006
Inspection Type: Complaint Critical Incident
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Lifecare Centre, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 22, 23, 24, 2024

The following intake(s) were inspected:

- Intake #00122028/ Critical Incident System (CIS) #2976-000041-24 related to alleged abuse a resident
- Intake #00123253/ CIS #2976-000045-24 related to COVID Outbreak
- Intake #00124825/ CIS #2976-000049-24 related to Medication Administration
- Intake #00126073 related to complaint about a social media post
- Intake #00127007 related to complaint about Medication Administration
- Intake #00127305 related to complaint about staffing levels
- Intake #00127955/ CIS #2976-000056-24 related to Fall Prevention and Management
- Intake #00129036/ CIS#2976-000058-24 related to Enterovirus - Rhinovirus Outbreak

The following intakes related to falls management were also reviewed:

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Intake #00122464/ CIS #2976-000042-24, #00126986/ CIS #2976-000052-24, #00128886/ CIS #2976-000057-24, #00126368 / CIS #2976-000051-24, and #00123125/ CIS # 2976-000044-24

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
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)
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 licensee has failed to ensure that the care set out in a resident's plan of care, specific to the implementation of a falls prevention plan was provided to the resident as specified in their plan.

Rational and Summary:
A resident had a fall resulting in injury.

During inspection the resident was observed without an intervention which was in their Care Plan. The concern was corrected before the inspection was completed.

There was minimal risk of harm to the resident.

Sources: Resident's plan of care; observations; and interviews with staff.

Date Remedy Implemented: October 23, 2024

WRITTEN NOTIFICATION: Orientation Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee failed to ensure that a staff member received required training prior to assuming their responsibilities upon hire.

Rationale and Summary:
A complaint and a Critical Incident System (CIS) report concerning a medication incident involving a resident were submitted to the Director.

The Registered Nursing staff member involved in the incident said during interview that they had not received any training or education on medication management or processing at the time of their hiring or thereafter, leading up to the incident.

The lack of required training posed a risk in the medication incident.

Sources: Review of the onboarding checklist for registered staff, interviews with staff, and an email from DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that medication administered to a resident was in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted to the Director and a complaint was also received by the Director, indicating that a resident did not receive their medication as ordered by the prescriber.

Record review indicated that the medication was not administered to the resident as ordered for a period of time.

This resulted in clinical symptoms and affected the resident's health and quality of life.

Sources: Review of the home's "Ordering and Receiving Medications Policy", resident's clinical records, and interviews with staff and Pharmacist.