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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 30, 2023

Inspection Number: 2023-1506-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: St. Joseph's Health System

Long Term Care Home and City: St. Joseph's Health Centre, Guelph, Guelph

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2023.09.11 14:47:24 -04'00'

Additional Inspector(s)
Brittany Nielsen (705769)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1-4 and 8-11, 2023.
The inspection occurred offsite on the following date(s): August 16-18, 2023.

The following intakes were inspected:

- Complaint intake #00091240 regarding the home's falls prevention and management program.
- Critical Incident (CI) intakes #00018886, #00022397, and #00020224 regarding the home's residents abuse and neglect program, and intake #00092182 regarding the home's falls prevention and management program.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The licensee has failed to ensure a resident's right to choose to have their dinner in the dining room was respected.

Rationale and Summary:
A resident requested to be transferred out of bed to attend their meal in the dining room.
A PSW did not assist the resident to eat in the dining room.

The DOC said the PSW should have listened to the resident and respected the resident's choice to have their meal in the dining room. As a result of the incident, the resident was emotionally impacted.

Sources: a resident's care plan, home's investigation records, and interview with staff [606]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary:
A concern was reported to the Ministry of Long Term Care (MLTC) regarding a resident's fall.

A PSW was portering the resident in heir wheelchair. The resident sustained injuries.

The resident's care plan said the resident required portering over long distances.

The care plan did not include any specific positioning techniques or position aides when the resident was portered long distances.

Two PSWs both stated that they did not use a specific positioning aide when portering the resident prior to the incident. One of the PSW stated they did not recall seeing a positioning aide available.

The Physiotherapist said a wheelchair with a specific positioning aide was provided to the resident when they were admitted and staff were expected to use the specific positioning aide when they portered the resident for proper positioning, and safety.

Failure to ensure the resident's plan of care provided clear directions to include that staff should porter the resident with a specific positioning aide on their wheelchair may have contributed to the resident sustaining an injury.

Sources: a resident's progress notes, care plan, physio assessments, and interviews with staff. [606]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary:
The home submitted a Critical Incident (CI) to the Director reporting an allegation of staff to resident abuse involving a PSW and the resident. The home's CI stated that the alleged abuse towards the resident occurred on an identified date and the PSW who witnessed the incident, did not report it to management until days later.

The DOC acknowledged that the incident should have been reported immediately to the Director.

By failing to report the allegation of abuse immediately, the licensee and Director were unable to respond to the incident in a timely manner.

Sources: A Critical Incident Report, the home's investigative notes, interviews with a PSW and the DOC. [705769]