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
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Original Public Report

Report Issue Date: December 4, 2023

Inspection Number: 2023-1506-0004

Inspection Type:
Complaint
Critical Incident

Licensee: St. Joseph's Health System

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

Lead Inspector	**Inspector Digital Signature**
Amanpreet Kaur Malhi (741128)	Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2023.12.22 13:03:00 -05'00'

Additional Inspector(s)
Diane Schilling (000736)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8-10, 14-17, 20-21, 2023

The following intake(s) were inspected:

- Intake #00092608, CI #3011-000031-23, and Intake #00096175, CI #3011-000039-23, related to falls
- Intake #00094483, CI #3011-000036-23, Intake #00096022, CI #3011-000038-23, and Intake #00096592, CI #3011-000040-23, related to resident to resident abuse
- Intake: #00096971, complaint related to resident's safety

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

A) The licensee failed to implement the safety interventions set out for a resident in their plan of care.

Rationale/Summary

1) Two residents had an altercation and as a result, a safety intervention was implemented for the resident.

An Inspector observed the safety intervention was not in place for the resident.

PSW #103 stated they were not sure why the intervention was not in place for the

resident.

2) The resident also had another safety intervention initiated related to other residents' responsive behaviors. Staff were directed to respond if alerted by the safety intervention to ensure the resident's safety.

An Inspector observed that the safety intervention was not active.

PSW #103 stated that the safety intervention was still in use for the resident, but was dependent on if it was activated.

The resident's safety was at increased risk when interventions were not implemented as set out in their plan of care.

Sources: Observations, Resident's Clinical Records and Interview with PSW #103.

[741128]

B) The licensee failed to ensure that a safety intervention was in place for a resident related to responsive behaviors exhibited by other residents.

Rationale and Summary

The resident's plan of care required staff to help them apply the safety intervention.

An Inspector observed the safety intervention was not in place for the resident while they were inside their room.

When a safety intervention was not applied as specified in the resident's plan of care, it increased the risk of harmful interactions with other residents.

Sources: Observations, and Resident's clinical records

[741128]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) The licensee failed to protect a resident from physical abuse by another resident.

Section 2 (1) (a), of the Ontario Regulation 246/22 defines physical abuse as, "the use of physical force by anyone other than a resident that causes physical injury or pain."

Rationale and Summary

Two residents had a physical altercation and one was injured.

As a result of the incident, the injured resident was emotionally impacted.

Sources: CI #3011-000040-23, Resident's clinical records, Multiple Issues Feedback Form -RL solutions, and interviews with staff
[741128]

B) The licensee failed to protect a resident from physical abuse by another resident.

Rationale and Summary

A staff member observed a resident kicking the other resident, leading to an injury to the other resident and causing agitation.

ADOC #102 stated that the resident had a condition, which made it challenging for them to express their needs and they could become aggressive when personal space was invaded.

Sources: CI #3011-000038-23, Resident's clinical records, and Interviews with staff

[741128]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (a)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;

The licensee failed to ensure that the written procedures set out in the home's Client Feedback (Compliments, Complaints and Suggestions) Process on how the licensee deals with complaints was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee is required to ensure that the procedure, is complied with.

Rationale and Summary

The Home's policy titled Client Feedback (Compliments, Complaints and Suggestions) Process, last revised on June 2023, required recipients of a complaint to respond immediately to address the issue, and to notify the respective Manager or appropriate person in a timely manner. Further it required recipient/Manager or delegate to gather initial information to identify what the complainant was concerned about, the implications of the complaint, the complainant's expectations and what needs to be done to reach resolution. It also required the recipient to assess the complaint severity and to consult with relevant stakeholder as needed. If a Manager/Director needed to be notified, the Feedback form of RL solutions was to be completed for tracking and trending purposes.

Over a weekend, a family member expressed concerns about their loved one's safety to a RPN in the home. They were advised to contact management on Monday in relation to their concerns.

ADOC #102 stated that during weekends or after hours, staff were expected to call the On-call Manager when approached by the resident's family re: safety concerns or when informed of the need to speak with the ADOC.

When the Client Feedback Process procedures were not complied with, it delayed

and undermined the effectiveness of addressing and resolving the resident's family's concerns related to their safety.

Sources: IL-17494-CW, ADMIN-002-3: Client Feedback (Compliments, Complaints and Suggestions) Process, last revised on June 2023, Resident's clinical records and Interviews with staff

[741128]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that a resident's responses to the safety interventions were documented.

Rationale/Summary

A) An Inspector observed a resident not following a safety intervention.

Staff stated that the resident did not like the safety intervention because it impacted

their freedom to move around.

B) An Inspector observed that the resident was scared of an aspect of a safety intervention.

Staff said the resident did not understand the safety intervention and would sometimes disengage it.

Another staff said the safety intervention also disturbed other residents on the neighborhood.

There was no documentation related to the assessment of the resident's responses to these interventions despite staff being aware of them. The resident's family member also indicated that these interventions were not working for them. It was not until more then two months later that the home followed up on the resident's responses.

Not documenting the resident's responses to the safety interventions increased the risk of ineffective care and may compromise their overall safety.

Sources: Observations, Resident's clinical record, and Interviews with staff

[741128]