Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: February 27, 2024	
Inspection Number: 2024-1506-0001	
Inspection Type: Critical Incident	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Health Centre, Guelph, Guelph	
Lead Inspector Yami Salam (000688)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6 - 9, 12 - 15, 20, 2024.

The following intake(s) were inspected:
·Intake: #00101982 – Related to neglect of a resident by staff
·Intake: #00103139 – Related to Falls Prevention and Management
·Intake: #00105499 – Related to COVID-19 Outbreak
·Intake: #00107024 –Related to COVID-19 Outbreak

The following intake was completed:
·Intake: #00103309 – Related to Falls Prevention and Management
·Intake: #00108046 – Related to COVID-19 Outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident responses to care interventions are documented.

Rationale and Summary:
A review of a resident's plan of care indicated that the resident required a specific care three times a day.

Two Personal Support Workers (PSW) stated that the resident refused the care; however, the refusal of care was not documented and registered staff were not notified.

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

The Director of Care stated that staff are expected to document refusal of care and inform the registered staff when a resident declines care.
Failure to document refusal of care by the resident, put them at risk of not receiving reassessments and/or adding new interventions in their plan of care.

Sources: review of the resident's clinical records, observation of the resident, interview with staff. [000688]

WRITTEN NOTIFICATION: Foot care and nail care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee has failed to ensure that a resident received fingernail care.

Rationale and Summary:
A concern was raised regarding fingernail care of a resident. The individualized plan of care for the resident instructed the staff to monitor the cleanliness of the resident's hands daily and clean as needed.

After multiple observations across two days, the resident's hands remained contaminated with debris under their fingernails.

Multiple staff members stated that the resident required under their finger nails cleaned daily, on shower days, and as needed.

Failure to adhere to the individualized nail care exposed the resident to potential infections.

Sources: Observation of the resident and review of their clinical records; and interviews with staff. [000688]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff.

A: The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023 (IPAC Standard) section 10.2 (c) related to resident hand hygiene stated that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals.

Rationale and Summary:
Inspector #000688 observed a dining service. None of the residents in the dining room received assistance with hand hygiene before and after their meal.

Two staff members stated that all residents were to be offered hand hygiene prior to and after meals.

By not performing hand hygiene, there was an increased risk of disease transmission among the residents and staff.

Sources: Lunch service observation , Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022, and interviews with staff. [000688]

B) The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023 (IPAC Standard) section 9.1 (f) stated at minimum additional precautions shall include additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Rationale and Summary:
While observing a home area under a declared COVID-19 outbreak, it was noted that several staff members did not adhere to the recommended procedures for donning, doffing, and disposing of PPE according to IPAC standards. Several staff members were observed not disposing their used PPE inside the residents room.

The IPAC associate stated that staff are expected to dispose their used PPE in the garbage bins inside the residents rooms.

By not using and disposing the PPE appropriately, there was an increased risk of spreading infection amongst the residents and staff.

Sources: Observations, interviews with staff. [000688]

C) According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022 revised September 2023, section 9.1, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: Point-of-care signage indicating that enhanced IPAC control measures are in place and additional Personal Protective Equipment

(PPE) requirements including appropriate selection, application, removal and disposal.

Rational and Summary:
The Local Public Health Unit recommended placing PPE donning/doffing signs at the entrance of residents' rooms. However, observations in the unit with a COVID-19 outbreak revealed that several rooms lacked these signs despite displaying droplet contact precaution signs.

The IPAC associate acknowledged being aware of the local public health unit recommendations.

Failing to adhere to these recommendations could lead to improper application, removal, and disposal of PPE by staff and potentially contributing to the spread of infection among residents and staff.

Source: Local Public Health Unit report, observations of the outbreak unit, interview with IPAC associate. [000688]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary:
The home filed two Critical Incident reports regarding COVID-19 outbreaks in separate home areas on different dates, both of which were submitted late to the Director.

The Assisted Director of Care (ADOC) stated that outbreaks should be reported to the Director immediately.

Failure to ensure immediate reporting of outbreaks to the Director may have resulted in delayed response to the incidents.

Sources: Interview with ADOC; Critical Incident Reports. [000688]