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
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Original Public Report

Report Issue Date: April 30, 2024
Inspection Number: 2024-1459-0002
Inspection Type: 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: 2024.04.30 15:33:04 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26, 29, 2024

The following intake(s) were inspected:

- Intake: #00110363, related to an unexpected death of a resident.
- Intake: #00113658, related to staff to resident abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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.

The licensee has failed to ensure a resident was protected from abuse by a staff member.

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

In an interview the resident confirmed the incident with a specific staff member, the incident made them feel scared.

In an interview a Personal Support Worker (PSW) said they witnessed the incident between the resident and the other PSW. The PSW said they did not intervene at the time of the incident.

In an interview the Acting Director of Care said the action by the staff member was considered to be abuse and the staff who witnessed the incident should have intervened to protect the resident and should have reported the incident immediately to protect the resident from similar incidents.

The resident was put at risk due to abuse and staff not intervening when they witnessed the incident.

Sources: record reviews, staff and resident interviews. [523]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance of Abuse

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

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

The home's policy stated "Document the current client/resident status on the health record and complete the required documentation for the MLTC"

A clinical record review for the resident showed no documentation about the resident's current status at the time the home was made aware of the incident.

In an interview the Acting Director of Care confirmed there was no documentation at the time of the incident or when they were made aware of the allegations. They said the policy was not complied with.

There was a risk as the home's policy to promote zero tolerance of abuse of residents was not complied with.

Sources: record reviews, 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) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of witnessed staff to resident abuse was immediately reported.

Rational and Summary:
The home submitted a Critical Incident System (CIS) Report related to an incident of staff to resident abuse that witnessed by another staff member.

In an interview the resident confirmed the incident with a specific staff member and

that the incident was witnessed by another PSW.

In an interview a Personal Support Worker (PSW) said they witnessed the incident between the resident and the other PSW. The PSW said they did not report the incident at that time as they did not think it was abuse.

In an interview the Acting Director of Care said the action by the staff member was considered to be abuse and the staff who witnessed the incident should have reported the incident immediately.

The resident was put at risk due to staff not immediately reporting witnessed staff to resident abuse.

Sources: record reviews, staff and resident interviews. [523]