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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 13, 2020	2020_796754_0022	007205-20, 008376-20, 011440-20, 013496-20	Complaint

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

Long-Term Care Home/Foyer de soins de longue durée

St. Joseph's Health Centre, Guelph
100 Westmount Road GUELPH ON N1H 5H8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TAWNIE URBANSKI (754), KIM BYBERG (729), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 4-7, 10-11, 2020.

The following intakes were reviewed during this complaint inspection:
Log #013496-20, an alleged incident of resident to resident physical abuse,
Log #008376-20, a complaint related to staffing shortages in the home and improper resident care,
Log #007205-20, a complaint related to responsive behaviors, and discontinuation of resident treatments,
Log #011440-20, a complaint related to improper care, documentation concerns, and communication concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nurse Practitioner, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), Recreation Staff, Wound Care Lead, Fall Lead, Behavior Support Lead, and the Physiotherapist.

The inspectors also toured resident home areas, observed resident care provision, and resident staff interaction, reviewed relevant residents' clinical records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from neglect or abuse by anyone in the home.

Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A complaint was submitted to the Ministry of Long-term Care which stated that resident #003 was abused by resident #004.

The incident note documented that resident #003 and resident #004 got into an altercation that resulted in an injury to resident #003.

The resident did not sleep due to the incident and the administered pain medication was not effective. Staff called the Medical Doctor (MD) for stronger pain medications.

Documentation showed resident #003 was repeatedly exhibiting symptoms of pain and distress. A new order was obtained for a stronger pain medication and this was given to the resident.

Recreation staff #111 said they witnessed the incident between resident #003 and #004 and that they considered it to be abuse.

Registered Nurse (RN) #101 said following the incident resident #003 had pain and required additional pain medication.

Behavioral Support RN #110 and Associate Director of Care (ADOC) #105 both said that the incident between resident #003 and #004 was physical abuse.

The licensee failed to ensure that resident #003 was protected from physical abuse by resident #004. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff., to be implemented voluntarily.

Issued on this 14th day of August, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.