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

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Original Public Report

Report Issue Date: November 24, 2022	
Inspection Number: 2022_1506_0001	
Inspection Type: Critical Incident System	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Health Centre, Guelph, Guelph	
Lead Inspector Katherine Adamski (753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2022.11.30 12:41:31 -05'00'
Additional Inspector(s) Mark Molina (#0000684) was also present for this inspection	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 31, November 1-4, 7-9, 2022

The following intake(s) were inspected:

- Intake: #00002163 - related to responsive behaviours
- Intake: #00005420 - related to fall prevention and management

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a)

The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents #001 and #002.

Rationale and Summary

Resident #001 had a history of behaviors and their care plan documented interventions for reducing incidents of behaviours.

Resident #002 was negatively impacted when staff or residents entered their room. It is unclear what interventions, if any, were in place at the time to keep co-resident's from entering resident #002's room. However, staff acknowledged that interventions to keep resident #001 from entering resident #002's room were not effective at the time of the incident.

Resident #001 entered resident #002's room where an altercation took place resulting in an injury to resident #002. Since this incident, resident #001 has continued to exhibit behaviours including entering other resident's rooms and was involved in altercations that put coresidents and staff at risk of harm.

Direct care staff stated that strategies for managing resident #001's behaviours remained unchanged since the altercation with resident #002. The Director of Care (DOC) acknowledged that resident #001's behaviours had been escalating and that they should have been re-assessed by the Behaviourial Supports Ontario (BSO) Program.

When procedures and interventions were not implemented to minimize the risk of altercations between resident #001 and #002, resident #002 was physically injured and residents and staff

continued to be at risk of harm.

Sources: Observations of resident #001 and #002, resident #001 and #002's plan of care including care plan with revision history, assessments, progress notes, orders, BSO Program Care Sheets, interviews with the Director of Care (DOC) and other staff.

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 failed to ensure that there was a written plan of care for resident #001 and #002 that set out clear directions to staff and others who provide direct care to the residents.

Rationale and Summary

The DOC stated that resident care needs were communicated to staff through care plans which documented the most accurate care requirements of a resident. Care plan documentation should be reflective of the care that was required to be provided to a resident with day-to-day changes communicated through shift report. Care plans were to be reviewed and revised quarterly, annually, and as needed when there was a change to a resident's care needs. Progress notes were not to be relied on for provision of care requirements.

a) There was a history of resident #002 being negatively impacted when coresidents entered their room. An altercation occurred when resident #001 entered resident #002's room which resulted in an injury to resident #002.

At the time of the incident, it is unclear what, if any, interventions were in place to keep resident #002 safe from coresidents entering their room. At the time of inspection, it was also unclear what interventions were in place to keep resident #002 safe.

Observations, statements from staff and the resident #002's plan of care related to the care provisions required for keeping resident #002 safe were not consistent and this put resident #002 at risk of another incident.

b) Resident #001 had a history of responsive behaviours, including physical and verbal aggression towards staff and coresidents.

Staff stated that resident #001 was most prone to exhibiting responsive behaviours during particular times of the day when a particular need was not met.

Resident #001's care plan with revision history did not identify interventions to manage all of their responsive behaviours. The BSO Program Care Sheet for resident #001 did not include interventions related to all of their responsive behaviours or triggers. At the time of inspection, resident #001's care plan also showed interventions that had been discontinued and were no longer being implemented according to staff.

Direct care staff stated that resident #001 had a particular intervention in place for the purpose of monitoring their whereabouts, and they were to be monitored and redirected from other coresidents to avoid potential triggers and altercations.

Observations showed a particular intervention was in place, however, it was not implemented by staff, despite staff stating it should be implemented. Resident #001 was observed in the presence of some of their identified triggers without supervision or redirection from staff.

When a written plan of care for resident #001 with clear directions to staff and others who provide direct care to the resident was not documented, it was unclear what care was required to be provided to the resident.

Sources: Observations of resident #001 and #002, resident #001 and #002's plan of care including care plan with revision history, progress notes, BSO Program Care Sheets, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: DOORS IN THE HOME

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were kept

closed and locked when they were not being supervised by staff.

Rationale and Summary

On three separate occasions, doors to the tub room and clean utility room on a particular unit were neither closed nor locked to restrict access to residents. The floor in the tub room was wet and there were no staff present in the area at the time of the observation. Registered Practical Nurse (#113) acknowledged that the doors should be closed and locked, at all times, when not in use. RPN #113 also acknowledged that the door to the tub room was open because it was difficult to close.

When the doors leading to the tub room and clean utility room were not closed and locked, there was a risk of residents wandering in and injuring themselves.

Sources: Observations, interview with RPN #113.

[#753]