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: February 21, 2023	
Inspection Number: 2023-1506-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Health Centre, Guelph	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.02.22 08:58:53 -05'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7-9, 14-16, 2023

The following intake(s) were inspected:

- Intake: #00017613 [Critical Incident (CI) 3011-000001-23] related to an unexpected death
- Intake: #00019362 [CI #3011-000005-23] related to alleged neglect, emotional abuse, and Residents' Bill of Rights

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

Infection Prevention and Control
Resident Care and Support Services
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident received proper care and services that were consistent with their needs.

Rationale and Summary
A resident indicated they used a device in their room during a specified time period and was asked to stop using it due to the home's policy. After that change, the resident stated they experienced symptoms each day. A request for the resident's window to be opened was requested two weeks later to help with the symptom's the resident experienced.

Two weeks after the device was no longer permitted to be used, a new device was provided to the resident. The family voiced concerns about the new device four days later. The resident indicated the new device was not effective and expressed frustration about not being able to use the original device to the Director of Care (DOC) a week after the new device was provided.

Five weeks after the original device was no longer permitted to be used, the DOC was provided with a note written by the resident's physician in the community. The physician had requested the use of the original device to help with the resident's symptoms, in addition to allowing the resident to open their window. These requests were declined at that time and no other alternatives were offered.

Assistant Director of Care (ADOC) stated that when a complaint is received, they would continue to offer alternatives until the concerns were resolved. They indicated the home would consult with other individuals in the home for suggestions to resolve concerns and would speak with the Nurse Practitioner (NP) to determine effectiveness of interventions.

The NP, who covered the home area where the resident resided, indicated they had not seen the physician letter that was provided to the home. They were also not aware the resident was experiencing symptoms after no longer using the original device. They indicated if they were aware, they would have assessed the resident and provided different alternatives to help meet their needs.

By failing to continue providing alternatives that met the resident's care needs, the resident continued to experience symptoms after the original device was no longer permitted to be used.

Sources: A resident's care plan and progress notes, email communication on specified dates, interviews with a resident, staff members, NPs, the ADOC, DOC and the Administrator.

[722374]