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

Original Public Report

Report Issue Date: September 16, 2024
Inspection Number: 2024-1506-0004
Inspection Type: Complaint Critical Incident
Licensee: St. Joseph's Health System
Long Term Care Home and City: St. Joseph's Health Centre, Guelph, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 22 - 23, 26 - 30, 2024 and September 3-6, 9, 2024.

The following intake(s) were inspected:
- Intake: #00116541 - Staff to resident abuse
- Intake: #00117420 - Concerns re: responsive behaviours of a resident housekeeping and plan of care
- Intake: #00118022 - COVID-19 Outbreak
- Intake: #00118024 - Staff to resident abuse
- Intake: #00118916 - Staff to resident neglect
- Intake: #00119191 - Concerns re: safe transferring and positioning
- Intake: #00123012 - Concerns re: LTCH handling complaints
- Intake: #00123427 - Unexpected death of a resident
- Intake: #00123527 – Concerns re: abuse and improper care of a resident
- Intake: #00123824 - Unexpected death of a resident

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management
Resident Charges and Trust Accounts
Admission, Absences and Discharge

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) 2.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to respect a resident's choice.

Rationale and Summary:

A long-term care homes (LTCH) inspector observed that a resident was not able to use a device in their room.

The resident stated that they would like to use the device but were not allowed and they felt as though they were being treated like a child.

Not allowing the resident to use the device in their room resulted in emotional impact to the resident.

Sources: Observation of the resident room, interviews with 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 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rational and summary:

A LTCH inspector noted that a resident's plan of care was not followed by staff.

A staff stated that for safety reasons, the resident's plan of care was not being followed.

The Assistant Director of Care stated that any changes in a resident's care status should be communicated to the team lead, who would then make appropriate

referrals for a reassessment. However, the resident was not referred for a reassessment.

When the resident was not reassessed and their plan of care revised when their care status changed, staff may have not known that the residents condition changed and the appropriate care method to use.

Sources: Observation and record reviews of the resident, interview with Assistant Director of Care and other staff.

WRITTEN NOTIFICATION: Plan of care
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when care set out in the plan had not been effective.

Rational and summary:

An intervention for continence care in a resident's plan of care had not been effective. However, the resident's plan of care was not revised and updated.

A staff stated that the resident's plan of care should have been updated to reflect the change.

The resident was at risk of not receiving appropriate care when their plan of care was not revised and updated.

Sources: Observation and medical record review of the resident, interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 a person who has reasonable grounds to suspect abuse or neglect of a resident by licensee or staff that resulted in harm or risk of harm was immediately reported to the Director.

Rationale and Summary:

The home had received multiple complaints of alleged harm and/or risk of harm to a resident. The home investigated the allegations, but did not report the concerns to the Director.

The Director was not able to make appropriate decisions when the home failed to report as required.

Sources: Internal Investigation Notes and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (4) (b)
Plan of care
s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 246/22, s. 29 (4).

The licensee has failed to ensure that a registered dietitian who is a member of the staff of the home assessed the nutritional status, including height, weight and any risks relating to nutritional care.

Rationale and Summary:
A resident had a choking incident. Multiple staff stated that prior to the incident, the resident was experiencing a concern while eating. However, there were no documentation or referrals to the Registered Dietitian (RD) regarding this concern.

The home's "Process for Nutrition Referral" Policy (LTC-041-3) states that upon identification of need for nutritional reassessment of a resident by the RD, a nutrition referral request is initiated electronically in the resident's plan of care.

The RD stated that they should have received a referral regarding the concern identified when the resident was eating food so that this behaviour could have been monitored. If they had a received a referral, the resident would have received an assessment and interventions could have been implemented as required.

When staff did not document or refer a risk related to nutritional care to the RD, the resident was not assessed for interventions to mitigate the risk.

Sources: Review of Resident's clinical records; interviews with staff; Process for Nutrition Referral Policy (LTC-041-3).

WRITTEN NOTIFICATION: Care conference

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

Care conference

s. 30 (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure multiple residents received an annual care conference.

Rationale and Summary:

A review of two resident's records revealed that they did not receive annual care conference.

LTC and Resident Care Coordinator acknowledged care conferences were not conducted, and said that the home is behind on conducting annual care conferences.

When care conferences were not conducted as required, residents and substitute decision makers missed an opportunity to share and discuss important matters related to the residents' plan of care.

Sources: Residents' clinical records and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when they assisted a resident.

Rational and summary:
Two staff members acknowledged that they did not use safe transferring techniques while transferring a resident.

As a result, the resident was put at risk when staff did not use safe transferring techniques.

Sources: Observation and record reviews of the, review of the home's internal investigation, interview with staff.

WRITTEN NOTIFICATION: Skin and wound care
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The Licensee has failed to ensure that a resident received a skin assessment by a

registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment,

Rational and summary:
A resident, with a pre-existing skin impairment, required a complete skin assessment after an incident.

The Assistant Director of Care (ADOC) stated that registered staff were required to conduct a full skin assessment, but did not.

The resident was at risk of not receiving immediate treatment when a full skin assessment was not completed for them after the incident.

Sources: Observation and record reviews of the resident, review of the home's internal investigation, interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment

instrument that is specifically designed for assessment of incontinence.

Rational and summary:
During an interview with two different staff members, it was noted that the continence status of a resident had changed.

The Director of Care stated that when the resident's continence status changed, registered staff were expected to complete an assessment to create individualized interventions, including evaluating the need for appropriate continence care products. However, no assessment was conducted for the resident following the change in their continence needs.

Failure to assess the resident when their care status changed could result in the resident not receiving consistent continence care and remaining comfortable.

Sources: Observation and medical record review of the resident, interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours
NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A) The licensee has failed to ensure that strategies were implemented when a resident demonstrated responsive behaviours.

Rationale and Summary
When a resident had exhibited responsive behaviours, two staff members did not follow the interventions for the management of the resident's responsive behaviours.

As a result of the staff not implementing the interventions related to the resident's responsive behaviours, the resident's behaviours escalated and they became more agitated.

Sources: The resident's care plan and incident report, interviews with staff.

B) The licensee has failed to ensure that strategies were implemented to respond to a resident when they demonstrated with physically responsive behaviours.

Rationale and Summary
A resident had known responsive behaviours during the provision of care. The resident's plan of care listed interventions to be followed during care.

On a specific day, when the resident exhibited responsive behaviours during care, multiple staff members did not follow the interventions set out in the resident's plan of care.

As a result, the resident and staff were placed at increased risk of harm by not implementing the interventions to manage the resident's responsive behaviours.

Sources: The resident's medical records, , interviews with staff.

WRITTEN NOTIFICATION: Menu planning
NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (c)
Menu planning

s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a resident was offered a minimum of a snack in the afternoon on a specific day.

Rational and summary:
A concern was raised regarding a resident's nutrition status and provision of an afternoon snack. A staff member stated that they were supposed to offer the resident an afternoon snack but they did not.

The resident was at risk of not meeting their nutrition needs when they were not offered an afternoon snack.

Sources: Observation and record reviews of the resident, review of the home's internal investigation and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program
NC #012 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 any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A. In accordance with the IPAC Standard, revised September 2023, section 9.1 d,

additional precautions must include both evidence-based practices related to contact precautions, as well as appropriate selection and application of personal protective equipment (PPE).

Specifically, the licensee has failed to ensure that a staff member complied with the appropriate application of PPE for a resident requiring contact precautions for direct care.

Rationale and Summary:
A staff member did not wear the required personal protective equipment (PPE) while assisting a resident with care.

When the staff did not select the appropriate personal protective equipment (PPE) for contact precautions while assisting the resident with care, it placed residents and themselves at risk of infection transmission.

Sources: IPAC Standard, 2023, observations of care, and interviews with staff.

B. In accordance with the IPAC Standard, revised September 2023, section 10.2 c, the hand hygiene program for residents shall include: assistance to residents to perform hand hygiene before meals and snacks.

Specifically, the licensee has failed to ensure that a staff member complied with the appropriate assistance of hand hygiene prior to a meal.

Rationale and Summary:
A LTCH Inspector observed a staff assist a resident into the dining room but did not assist the resident to perform hand hygiene upon entering the dining room or at any point during the course of the meal.

The staff stated that they were to assist residents with hand hygiene before a meal but they did not.

The IPAC Lead stated that hand hygiene was to be performed with residents before and after dining.

When the staff member did not appropriately assist the resident with hand hygiene prior to a meal, it placed the resident and others at risk of infection transmission.

Sources: IPAC Standard, 2023, observations, interviews with staff.

C. In accordance with the IPAC Standard, revised September 2023, section 7.3, (b), the IPAC Lead shall ensure that audits are performed as required.

Specifically, the licensee has failed to ensure that the IPAC Lead had implemented audits, at least quarterly, to confirm that all staff can perform the IPAC skills required of their role.

Rationale and Summary:
The IPAC Associate provided audits for Personal Protective Equipment (PPE).
The PPE audits did not include all units and disciplines and did not meet the requirements of confirming that all staff can perform the IPAC skills required of their role.

When there failed to be quarterly IPAC skills auditing, it placed the residents and staff at risk of infection transmission.

Sources: IPAC Standard, 2023, audits of hand hygiene and PPE, and interviews with staff.

WRITTEN NOTIFICATION: Emergency plans

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,

vi. medical emergencies,

The licensee has failed to ensure that the emergency plan provided for dealing with medical emergencies, was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their emergency plan for medical emergencies was complied with.

Specifically, staff did not comply with the policy "Nurse Stat", revised April 2023, during an emergency.

Rationale and Summary:

During an emergency situation with a resident, the emergency procedures were not followed.

When staff did not follow the process for emergency situations outlined in the homes policy, it put the resident at risk of not receiving additional medical intervention if needed.

Sources: The resident's medical records; interviews with staff; Nurse Stat Policy revised April 2023.

WRITTEN NOTIFICATION: CMOH and MOH

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

In accordance with the Ministry of Health "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", effective April 2024, section 5.1, all healthcare workers interacting with a suspect or confirmed case of COVID-19 should wear eye protection, gown, gloves, and a well-fitted or N95 mask.

Specifically, the licensee has failed to ensure that a staff member complied with the appropriate application of PPE when they provided care for a resident who was on droplet precautions due to suspected COVID-19.

Rationale and Summary:

A staff member interacted with a resident who was on precautions for suspected Covid-19. The staff member did not wear the appropriate PPE for the duration of their interaction with the resident and their environment.

The IPAC Associate stated that staff were required to wear appropriate PPE when walking a resident who was on contact precautions.

The residents were placed at risk of infection transmission when staff member did not select the appropriate personal protective equipment (PPE) for droplet precautions and assisted the resident.

Sources: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Setting April 2024, observations and interview with staff.