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: November 5, 2024
Inspection Number: 2024-1506-0005
Inspection Type: 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): October 23-24 and 28-29, 2024.

The following intake(s) were inspected:

- Intake: #00125640 - improper/incompetent care of a resident by staff.
- Intake: #00128672 - resident-to-resident physical abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 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

1. The licensee has failed to ensure that strategies were implemented to respond to responsive behaviours demonstrated by a resident.

Rationale and Summary

A resident had an intervention implemented by the Behavioural Supports Ontario (BSO) team related to their responsive behaviours.

The identified intervention was observed to not have been implemented.

By failing to implement the strategies to respond to a resident's responsive behaviours, it could have led to further incidents with other co-residents.

Sources: A resident's clinical health records, observations, Critical Incident (CI) report; and interviews with the Director of Care (DOC), BSO Personal Support Worker (PSW), and other staff members.

2. The licensee has failed to ensure that strategies for managing responsive behaviours were implemented for a resident.

Rationale and Summary
A resident's plan of care stated they can be resistive to care and identified interventions to manage the behaviour.

Two personal support workers (PSW) provided care to the resident who was resistive at the time and did not follow the interventions outlined in the resident's plan of care.

As a result of not following the strategies identified in the resident's plan of care, the resident was injured.

Sources: Record review of a resident's care plan and Critical Incident (CI) report; and interviews with Personal Support Worker (PSW), Registered Nurse (RN), BSO Personal Support Worker (PSW), and Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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
A physical altercation was observed between two residents, during which one of the resident's sustained a skin tear.

The Director of Care (DOC) confirmed the situation was not reported to the Director until a day later, and no after-hours reporting was made.

By not immediately reporting the incident of abuse towards the resident, the Director was unable to respond immediately.

Sources: Review of Critical Incident (CI) report; and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including, identifying and implementing interventions.

Rationale and Summary

The Director of Care (DOC) stated that, following an altercation, a new intervention was implemented for a resident to prevent further altercations with other residents.

The resident was observed, and the new intervention was not in place at the time of the observation.

By failing to implement the identified intervention to minimize the risk of altercation between residents, there was a risk that another altercation could occur.

Sources: Review of a resident's clinical health records and Critical Incident (CI) report; observations and interviews with Director of Care (DOC), BSO Personal Support Worker (PSW), and other staff members.