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

Public Report

Report Issue Date: December 19, 2024
Inspection Number: 2024-1506-0006
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): December 2 - 6, 9 -10, 12 - 13, 2024

The following intake(s) were inspected:

- Intake: #00128096 – Prevention of Abuse and Neglect, Responsive Behaviours
- Intake: #00129771, #00130315, #00132922 – Infection Prevention and Control
- Intake: #00131335 – Food, Nutrition and Hydration, Prevention of Abuse and Neglect

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee failed to ensure that a resident was protected from abuse.

Rationale and Summary
A resident sustained minor injuries during an altercation with another resident.

Sources: CI Report 3011-000042-24, progress notes, and interviews with PSW, RPN, and BSO Lead.

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 failed to report resident to resident abuse to the Director.

Rationale and Summary

An altercation between two residents which resulted in pain to one resident was not reported to the Director.

Sources: resident's progress notes and interview with ADOC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 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 failed to ensure safe transferring techniques were used when transferring a resident.

Rationale and Summary:

Unsafe transferring techniques were used when two PSWs transferred a resident to the toilet.

The DOC stated that the PSW should have completed an assessment to ensure the straps were in the right place prior to the transfer.

Failure to use safe transferring and positioning techniques resulted in a resident having pain following being lifted and also resulted in damage to the transport equipment.

Sources: progress notes, care plan, interview with DOC, resident and staff.

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #004 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 failed to ensure steps to minimize risks of altercations and harm were implemented.

Rationale and Summary
A resident was to have a support present. The support was pulled to another unit, after the support was removed, an altercation between two residents occurred which resulted in minor injuries.

When the home failed to implement the support that was identified to minimize the risk of altercations for a resident, they had an altercation with another resident which resulted in injury.
Sources: Resident's progress notes and care plan and interviews with PSW, RPN, and DOC.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that staff used proper feeding techniques when assisting a resident.

In accordance with O. Reg. 246/22 s. 11 (1) b, the home's LTC Nutrition and Hydration program, edited Dec 1, 2023, said appropriate assistance must be provided to residents at meals and snacks.

Rationale and Summary:
On observation completed during dining showed a PSW was not following proper techniques when they fed a resident.

Training on the home's process for feeding techniques included that staff should be seated at eye level for feeding.

The PSW and the dietitian acknowledged that staff should be seated at eye level to feed residents.

Sources: LTC Nutrition and Hydration program, edited Dec 1, 2023, Training: pleasurable dining, revised Dec 6, 2023, interviews with Dietitian and PSW.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 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).

A. In accordance with the IPAC Standard, revised September 2023, section 10.4, (h), the Licensee shall ensure there is support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Specifically, the licensee has failed to ensure that the residents received support to perform hand hygiene prior to receiving meals.

Rationale and Summary
During the inspection staff were observed on multiple units not supporting residents with hand hygiene before the lunch meal. The inspector checked the Alcohol-Based Hand Rubs (ABHR) mounted on the walls to ensure that they were working. Bottles of ABHR were located on tables as well. Staff performed hand hygiene on themselves before entering the dining area and after interacting with residents but failed to support residents with hand hygiene.

The Inspector interviewed a PSW and the IPAC Associate who both confirmed that staff were to support residents with hand hygiene before meals.

Source: Observations and interviews with staff.

B. In accordance with the IPAC Standard, revised September 2023, section 9.1 (d) the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: proper use of PPE, including appropriate selection, application, removal, and disposal.

Specifically, the licensee failed to ensure staff donned appropriate PPE prior to entering a room with additional precautions.

Rationale and Summary
A PSW entered a resident's room with additional precautions. They entered without donning the proper PPE. When they were questioned, they stated that they were supposed to don a gown before entering the room.

Failure to don appropriate PPE placed the residents and staff at risk of infection transmission.

Source: Observation and interview with PSW and IPAC Associate.

C. The licensee failed to ensure staff implemented IPAC standards related to PPE doffing and hand hygiene.

Rationale and Summary:
A PSW was observed going in and out of multiple rooms including resident's rooms without removing their gloves and mask. They did not remove their gloves or sanitize their hands.

The PSW confirmed they had not removed their gloves or done hand hygiene when they exited the resident's room.

The IPAC lead said the staff member should remove gloves prior to exiting a resident's room and clean their hands. New gloves should be donned for a new task.

Failing to doff the gloves and complete hand hygiene following care, put other staff and potentially residents at risk of exposure to potential infectious pathogens.

Sources: observations, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, MLTC, Effective 2024, interviews with IPAC Associate and PSW.

WRITTEN NOTIFICATION: Reports re Critical Incident

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to report an outbreak immediately after Public Health confirmed the home was in outbreak.

Rationale and Summary
The home was declared in outbreak , and the home reported it to the Director two days later.

Assistant Director of Care (ADOC) stated that the on-call manager, who is not from the Long-Term Care side of the company, was not aware that the Ministry was to be informed about an outbreak in the home.

Source: Critical Incident Report 3011-000065-24 and interviews with IPAC Associate and ADOC.