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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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: December 19, 2024

Inspection Number: 2024-1506-0007

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): December 3 - 6, 9 - 10, 12 - 13, 2024
The inspection occurred offsite on the following date(s): December 16 - 17, 2024

The following intake(s) were inspected:

- Intake: #00131234, #00131332, #00133772, #00133787 - Prevention of Abuse and Neglect.
- Intake: #00133149 - Continence Care
- Intake: #00133278 - Food, Nutrition and Hydration, Falls Prevention and Management, Residents' Rights and Choices, Medication Management, Safe and Secure Home

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

Continence Care
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home

Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

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) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that staff treated a resident with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Rationale and Summary:
A complaint to the Ministry of Long Term Care indicated that staff were not respectful in how they addressed a resident.

An observation showed a PSW called a resident by a term of endearment instead of

by their given name.

The PSW acknowledged they were aware the resident did not wish to be addressed by this term of endearment.

Failure to address the resident by their preferred/given name does not show the resident courtesy and respect or recognize their inherent dignity, worth and individuality.

Sources: Complaint, observations, interview with staff.

WRITTEN NOTIFICATION: Maintenance Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee failed to ensure that schedules and procedures were in place for routine, preventive and remedial maintenance - specific to flooring.

Rationale and Summary:
A complaint to the Ministry of Long Term Care indicated concerns related to a tripping hazard in a resident's room.

Observations showed modifications to the floor in a resident's room. Observations of three additional randomly selected rooms showed cracking and peeling in another

resident's room as well.

There were multiple concerns identified and submitted via Worx Hub, the system for requesting maintenance work, related to the flooring. Four of the concerns submitted identified this was a tripping hazard.

The maintenance supervisor said that the home did not have schedules or procedures in place for preventive maintenance related to flooring surfaces. They said that a contractor had been consulted to complete the repairs in October 2024, however they had not been able to attend to the job at the time. The maintenance supervisor confirmed the repairs were being made in December 2024.

Failure to have documented schedules or procedures in place for routine, preventive and remedial maintenance can increase the risk of injury to residents when issues are not prevented or addressed in a timely manner.

Sources: complaint intake, observations, Worx hub, interview with Maintenance supervisor and staff.