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

Public Report

Report Issue Date: March 28, 2025

Inspection Number: 2025-1506-0003

Inspection Type:
Complaint
Critical Incident
Follow up

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): March 10-14, 17-21, 24-27, 2025

The following intake(s) were inspected:

- Intake: #00134294, #00136287, #00138681, #00137632, #00138873 - related to prevention of abuse and neglect
- Intake: #00138453 - related to responsive behaviours
- Intake: #00138467- related to the unexpected death of a resident

The following complaint intake(s) was inspected:

- Intake: #00135002 – related to concerns with resident care

The following follow-up intake(s) was inspected:

- Intake: #00139183 - CO #001 from inspection 2025-1506-0001 - related to resident bill of rights

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1506-0001 related to FLTCA, 2021, s. 3 (1) 17.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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; or

The licensee failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed and the care set out in the plan was no longer necessary.

A resident's plan of care did not accurately reflect their interventions, but was updated immediately upon notifying management of the discrepancy.

Sources: observations, kardex and care plan, interviews with ADOC #114 and other staff.

Date Remedy Implemented: March 24, 2025

WRITTEN NOTIFICATION: Duty to Protect

NC #002 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 protect a resident from abuse by another resident.

Ontario Regulation 246/22, states that physical abuse is the use of physical force by a resident that causes physical injury to another resident.

Two residents had an altercation resulting in an injury to one of the residents.

Sources: Resident care plans, progress notes, and assessments, interview with the Assistant Director of Care (ADOC) #114 and other staff.

WRITTEN NOTIFICATION: Reports of Investigation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A) The home completed their investigation into an incident of alleged staff to resident physical abuse and did not report their results to the Director.

B) The home completed their investigation into an incident of alleged resident to resident physical abuse and did not report their results to the Director.

Sources: interview with the ADOC #114

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the home's skin and wound program was complied with.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies and procedures developed for the skin and wound program were complied with.

As per the home's Skin and Wound policy, Personal Support Worker (PSW) staff were required, but failed to document that they had identified skin concerns on a resident.

Sources: Skin and Wound Program & Process Policy, interviews with PSW staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, that a pain assessment that was considered part of the post-fall assessment was conducted using a clinically appropriate instrument that was specifically designed for falls.

Sources: Falls Prevention and Management Program & Process Policy, PointClickCare documentation, Post-Fall Assessment, interview with a Registered

Practical Nurse (RPN)

WRITTEN NOTIFICATION: Maintenance Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee failed to ensure that when a resident's device was malfunctioning, staff implemented the home's
procedures for replacing the device.

Sources: observations, resident progress notes, kardex and interviews with the resident and staff.

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

(1) Re-educate PSW staff and the ADOC #114 on mandatory reporting requirements as per FLTCA, 2021 and O. Reg. 246/22, related to abuse and neglect. This must include a review on the mandatory reporting process, what constitutes abuse and neglect, and staff roles and responsibilities for reporting and responding to alleged, suspected, and witnessed incidents of abuse and neglect.

(2) A record of the education provided must be kept in the home. The record must include all materials reviewed, the date(s) the education was provided and completed, the name(s) of the person(s) who provided the education, and signed by staff.

Grounds

A) The licensee has failed to comply with s. 28 (1) 2. when a RPN and registered nurse (RN) had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director.

Pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Two registered staff did not immediately report an allegation of staff to resident physical abuse.

Sources: the home's internal investigation, interviews with the ADOC #114

B) The licensee has failed to ensure that when PSW staff had grounds to suspect

physical abuse resulting in harm and neglect to a resident occurred, that the information was immediately reported and the information upon which it was based to the Director.

Pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

As part of the home's internal reporting protocol, staff were required to immediately inform a manager of any incident of alleged or witnessed abuse or neglect. Next, the Manager was required to immediately initiate a Critical Incident (CI) System report upon notification of a witnessed or suspected incident of abuse or neglect that resulted in any form of harm.

A PSW witnessed an incident of resident-to-resident physical abuse resulting in harm.

Multiple PSW's identified additional health concerns as a result of the incident and alleged that the RPN did not assess the resident. Several hours later, the resident passed away.

PSW staff did not report the witnessed incident of resident abuse and allegations of staff to resident neglect to management, immediately.

Upon management being informed of the allegation, the Director was not immediately informed of the witnessed incident of physical abuse that resulted in harm and alleged incident of neglect to the resident.

Sources: Zero Tolerance of Abuse and Neglect Policy, interviews with the ADOC #114 and other staff

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #002 General Requirements

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

(1) Review and update the Head Injury Routine (HIR) policy and the Neurological Flow Sheet guidance tool to ensure that the procedures are in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.

(2) Educate all registered staff on the home's updated HIR policy and Neurological Flow Sheet guidance tool. There must be a record kept of the education provided including the name(s) of the person(s) who provided the education, dates and times of when the education was provided, and signatures of the staff who attended the education.

(3) Conduct audits on a minimum of five HIR assessments completed at the home to

ensure accuracy and follow up on any discrepancies or concerns identified. The audits should capture a variety of home areas, if possible.

(4) The audits should be documented and signed by the person(s) conducting the audits. They should also include the names of the staff members who completed the HIR assessments, the dates of when the audits were completed, and corrective actions taken (if any).

Grounds

The licensee has failed to ensure that the home's falls prevention and management program that was evaluated in May 2024 was updated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

As per the home's falls prevention and management program, staff were required to complete a HIR assessment using the Neurological Flow Sheet guidance tool for a 72-hour period. According to the tool, staff were directed to obtain vital signs at a reduced frequency in comparison to the neurological checks of the assessment tool.

The Director of Care (DOC) stated that the HIR protocol related to the reduced frequency of obtaining vital signs had been in place since December 2019. The home was unable to provide evidence or best practices to support this practice.

A resident fell and had a suspected head injury.

The resident's post fall assessments were reviewed, and the documentation was incomplete. The most recent assessment showed a parameter that was outside of normal ranges. The DOC stated that they would not have expected staff to conduct additional assessments because the guidance tool did not require them to do so.

Registered staff did not assess the resident throughout the night because they stated that assessments were not typically conducted while residents were sleeping. The resident was found deceased in the middle of the night.

Failure to ensure that the home's post-fall assessment protocol was updated in accordance with evidence-based practices or prevailing practices, placed a resident with a suspected head injury at actual risk of harm.

Sources: Falls Prevention and Management Program & Process, HIR Policy, resident post-fall assessment records including their Neurological Flow Sheet record, Falls Prevention and Management Annual Program meeting minutes for May 2024, E-mail correspondence from the home's Organizational Learning and Development department, interviews with the DOC and other staff.

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #003 Policy to Promote Zero Tolerance

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

(1) Ensure that every witnessed, suspected, or alleged incident of abuse, neglect, and/or improper care related to a resident is investigated as per the home's zero tolerance of abuse and neglect policy.

(2) Ensure that the incident of abuse involving two identified resident's are re-investigated as per the home's zero tolerance of abuse and neglect policy.

(3) The records of the investigation process must be documented and be available upon an inspector's request. This must include staff interviews with their responses documented, written and signed statements from witnessed staff members, notification to family, all materials reviewed, and disciplinary actions taken (if any).

Grounds

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A) Specifically, the zero tolerance of abuse and neglect policy required a member from the management team to conduct an internal investigation of all alleged, suspected, or witnessed incidents of abuse and to ensure that the following are completed as part of the process:
- The next of kin/substitute decision maker (SDM)/Power of Attorney (POA) must be notified within 12 hours of becoming aware of the incident.
- The preliminary investigation included interviews with all staff who worked on the shift involved and the names of anyone who may have knowledge of the circumstances surrounding the incident and that written signed statements from witnesses are obtained.

A Critical Incident (CI) report was submitted to the Director related to an incident of unexpected death of a resident following a falls incident.

Upon review of the home's internal investigation records for this incident, the home did not inform all of the required individuals, and did not interview and document all staff involved in the incident, as per their policy.

During their interview with the home, one PSW alleged resident-to-resident physical abuse and staff to resident neglect.

An investigation into the allegations of staff to resident neglect was not completed, staff who worked that shift were also not interviewed and there was no next of kin notification related to the witnessed incident of abuse and allegation of neglect.

The home did not follow their policy related to investigations of incidents of alleged abuse or neglect.

Sources: Zero Tolerance of Abuse and Neglect Policy, LTCH's investigation notes, residents medical records, interviews with the Coroner, ADOC #114 and other staff.

B) The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

When conducting their internal investigation of resident to resident physical abuse, the home did not comply with their Zero Tolerance of Abuse and Neglect Policy which directed them to photograph injuries and interview all staff who worked on the shift involved.

Sources: Zero Tolerance of Abuse and Neglect Policy, the home's internal investigation, interviews with ADOC #114 and other staff.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #004 Altercations and other interactions between residents

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 59 (b) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:The Licensee shall prepare, submit, and implement a plan to ensure interventions are implemented to minimize the risk of altercations between resident #002 and their co-residents.

The plan shall include but is not limited to:

(1) A plan to ensure the following staff are familiarized with a resident's behavioural triggers and interventions to minimize the risk of altercations between the identified resident and co-residents, including residents with whom they are at increased risk of conflict:
(A) 1:1 staff.
(B) In the event 1:1 staff are reduced or discontinued, direct care nursing staff.

(2) A plan to discuss room location preferences with identified residents, as appropriate with ongoing management of a resident's responsive behaviours. Ensure the plan for the discussion(s) includes a contingency if it will be delayed.

Please submit the written plan for achieving compliance for inspection 2025-1506-0003 to Kailee Bercowski, MLTC Homes Inspector by April 10, 2025.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

Grounds

The licensee failed to ensure interventions to minimize the risk of altercations between a resident and their co-residents were identified and implemented.

A resident had known responsive behaviours towards co-residents and they were at an increased risk of altercations with co-residents.

For a period of time, the resident had several altercations with their co-residents and no changes were made to the resident's care plan to mitigate the risk of future altercations.

Sources: Interviews with residents and staff of the home, resident clinical records.

This order must be complied with by May 12, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.