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: June 12, 2025

Inspection Number: 2025-1506-0004

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): June 2 - 6, 9 - 12

The following intake(s) were inspected:

- Intake: #00141685, #00141726, and #00143416 related to allegations of physical abuse.
- Intake: #00142925 complaint related to allegations of improper care.
- Intake: #00142937 and intake #00142941 related to allegations of emotional abuse.
- Intake: #00143446 related to infection prevention and control.
- Intake: #00145277 related to allegations of improper care.
- Intake: #00143656 - Follow-up #: 1 – CO #001 / 2025_1506_0003, FLTCA, 2021 - s. 28 (1) 2.
- Intake: #00143657 - Follow-up #: 1 – CO #002 / 2025_1506_0003, FLTCA, 2021 - s. 34 (1) 3.
- Intake: #00143659 - Follow-up #: 1 – CO #003 / 2025_1506_0003, FLTCA, 2021 - s. 25 (1).
- Intake: #00143658 - Follow-up # 1 - CO #004 / 2025_1505_0005, O. Reg. 246/22 - s. 59 (b).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1506-0003 related to FLTCA, 2021, s. 28 (1) 2.
Order #002 from Inspection #2025-1506-0003 related to O. Reg. 246/22, s. 34 (1) 3.
Order #003 from Inspection #2025-1506-0003 related to FLTCA, 2021, s. 25 (1)
Order #004 from Inspection #2025-1506-0003 related to O. Reg. 246/22, s. 59 (b)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 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.

A) The licensee failed to ensure that the Director was immediately informed of an incident between two residents, as required.

Sources: Record review of the Critical Incident (CI) Report, and resident progress notes.

B) The licensee has failed to ensure that a person who had reasonable grounds to suspect neglect of a resident immediately reported it to the Director.

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

An allegation of neglect was reported to staff but they did not immediately report it to management. Consequently, the allegation was not immediately reported to the Director.

Sources: resident's progress notes, the home's investigative notes, interview with an assistant director of care.

WRITTEN NOTIFICATION: Doors In A Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following

rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the inspection, an inspector observed multiple doors leading to non-residential areas that were left open and/or unlocked. Some of these non-residential areas had electrical equipment and/or tripping hazards that posed a risk to resident safety.

Sources: Observations during inspection and interviews with multiple staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
(1) A plan to ensure that registered staff on the Blue Spruce Trail unit are re-educated on the process for re-ordering and receiving medications dispensed by the pharmacy, and what follow-up actions are required to ensure that the medication was received.

(2) A plan to ensure that PSW staff on the Blue Spruce Trail implement the home's processes for communicating resident pain, refusals and other concerns to registered staff. This plan must also ensure that the registered staff are aware of

what actions to take in response to such reports including assessments, treatments, accurate documentation and notifying the resident's SDM.

(3) A plan to ensure that a resident receives care as required, including that the care is completed by the required staff, at the required times, using the required products, and is accurately documented.

Please submit the written plan for achieving compliance for inspection #2025-1506-0004 to the Ministry of Long-Term Care, by email to centralwestdistrict.mltc@ontario.ca by June 27, 2025.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

A) The licensee failed to protect a resident from emotional abuse by a care provider.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident was overheard screaming while receiving care. Despite being asked to stop by the resident, care continued to be provided. Afterwards, multiple staff reported the resident to be upset and crying.

Sources: Critical incident report, the home's investigation notes, resident's clinical records, and interviews with staff.

B) The licensee failed to ensure that a resident was protected from neglect.

In accordance with Ontario Regulation 246/22, s. 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was at high risk for specific health concerns with a history of risk factors. The resident required staff to provide care at specified times using specified products.

Over several months, the resident's health deteriorated, and the resident's substitute decision maker (SDM) was not informed.

The home completed an investigation into the concerns and staff acknowledged that they were not providing the care as required, and had not reported concerns that they had identified with the resident's health and therefore, no follow-up actions were taken.

At the time of the inspection, staff did not provide care at the specified times using the specified products and documented the provision of care inaccurately.

The resident's health condition deteriorated resulting in a significant change in their health status.

Sources: observations, resident's care plan, progress notes, assessments, electronic Treatment Administration Record, POC task documentation, drug record book, interviews with an assistant director of care and other staff

This order must be complied with by July 25, 2025

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
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Telephone: (888) 432-7901

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.