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
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Public Report

Report Issue Date: September 24, 2025

Inspection Number: 2025-1506-0006

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): September 17-19, 22-24, 2025

The following intake(s) were inspected:

-Intake: #00157016 - CI#3011-000052-25: Fall Prevention and Management
-Intake: #00157585 - CI#3011-000054-25: Responsive Behaviours

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

Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: 24-Hour Admission Care Plan

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (4)
24-hour admission care plan
s. 27 (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 51 of the Act. O. Reg. 246/22, s. 27 (4).

The licensee failed to ensure that the care set out in the care plan for a resident was based on the needs of the resident, and the information provided by the placement coordinator.

A resident's care plan was not based on their needs, the information provided by the placement coordinator and staff resulting in an incident occurring.

Sources: a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: General Requirements

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that staff accurately documented a resident's responses to their responsive behaviour interventions.

Sources: a resident's clinical records and interviews with staff.