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

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Public Report

Report Issue Date: December 2, 2025
Inspection Number: 2025-1520-0009
Inspection Type: Critical Incident
Licensee: St. Joseph's Health Care, London
Long Term Care Home and City: Mount Hope Centre for Long Term Care, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 24, 25, 27, 28, 2025 and December 2, 2025
The inspection occurred offsite on the following date(s): November 26, 2025 and December 1, 2025

The following intake(s) were inspected:
-Intake 00158701 / #C596-000173-25 related to improper care

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A resident who exhibited altered skin integrity was not reassessed at least weekly as clinically indicated.

The clinical records for a resident indicated altered areas of skin integrity which were initially assessed, however, the areas were not reassessed weekly according to the resident's treatment records.

The skin and wound lead acknowledged that the skin tears were not reassessed weekly.

Sources: Resident clinical records; interview with the skin and wound lead.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

When a resident demonstrated responsive behaviours, the strategies to respond to these behaviours were not implemented.

An incident of staff to resident incompetent/improper treatment or care was identified by the home, when a resident expressed responsive behaviours during care. Staff members continued to provide care to the resident which was not indicated in the residents clinical records.

The Interim Director of Clinical Services and Resident Care and the Manager of Resident Care confirmed that the documented strategies and interventions to respond to the resident's behaviours were not implemented as per the plan of care.

Sources: The critical incident report and the home's investigative notes; resident clinical records; Interview with the Interim Director of Clinical Services and Resident Care, and the Manager of Resident Care.