Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: February 10, 2026
Inspection Number: 2026-1520-0001
Inspection Type: Complaint 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): January 14-16, 19-23, and 26-30, 2026 and February 2-6, 9, 10, 2026
The inspection occurred offsite on the following date(s): January 21, 27, 2026

The following intake(s) were inspected:
- Intake: #00163402 / C596-000196-25 related to an Environmental Hazard
- Intake: #00163927 related to a complaint with the home's admission process
- Intake: #00164172 / C596-000198-25 related to an allegation of abuse
- Intake: #00164608 / C596-000199-25 related to an influenza outbreak
- Intake: #00165632 / C596-000206-25 related to the fall of a resident resulting in injury
- Intake: #00166532 / C596-000211-25 related to the fall of a resident resulting in injury
- Intake: #00167168 related to a skin and wound care complaint

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

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: 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.

Doors to two non-residential areas, a soiled utility room and a clean utility room, were observed to be open with no staff supervision. Upon review, floor staff confirmed the doors should not be open. The staff closed the doors and they were confirmed to be locked.

Sources: Observation of the non-residential home areas; Interviews with staff.

Date Remedy Implemented: January 14, 2026

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

A servery was observed and noted with a build up of dirt and grime around the perimeter of the floor at the base of the cabinets. An adjacent dining room was also observed and noted with a build up of dirt and grime around the perimeter of the floor, the window ledges and walls. The Food Service Specialist and Manager of Food & Nutrition Services observed the areas and confirmed the areas were not at an acceptable level of cleanliness.

A thorough clean of the dining room and servery were completed.

Sources: Observations of the servery and dining room; Review of the home's

Department Duty List; Interviews with staff.

Date Remedy Implemented: January 28, 2026

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The care set out in the plan of care for a resident was not provided to the resident as specified in the plan.

A physiotherapist and a external physician made a recommendation for an assistive device to be used by a resident with an injury. The resident's physician ordered the use of the assistive device. On follow-up, the external physician's report indicated the assistive device was again recommended. There were no orders to discontinue the use of the assistive device or notes to indicate when or why the device was discontinued.

During observations of the resident, they were not using the assistive device.

In an interview with a Manager of Resident Care (MRC), they stated the device was not available in the home for the resident to use until almost one month after the initial physiotherapist recommendation to consider the use of the device for comfort. In an interview with a staff member, they reported the resident declined to use the device. The resident's wishes were not documented.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Plan of Care - When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 plan of care for a resident included an allergy/sensitivity to a group of medications. The plan of care was not updated to indicate a medication, that is part of the potential allergen group, was permitted. The Medication Administration Records (MAR) showed the resident had been receiving the medication every four hours as needed.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 staff did not immediately report allegations of abuse made by a resident to a manager in the home, as required by the home's policy, or to the Director. This contributed to a delay in the mandatory immediate reporting of allegations of abuse to the Director. The critical incident was reported to the Director more than 24 hours later.

Sources: The Critical Incident report and the home's internal investigation notes; Interviews with staff.

WRITTEN NOTIFICATION: 24-hour Admission Care Plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 2.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

A resident had a history of responsive behaviours. The resident's 24-hour care plan had not been updated to be individualized to the resident, and did not include risks the resident may pose to others, including potential behavioural triggers, and safety measures to mitigate those risks.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Care conference

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

An annual care conference of the interdisciplinary team was not held within the required timeframe to review a resident's plan of care and any matters of importance to the resident and their substitute decision-maker.

Review of the resident's documentation showed the resident exhibited responsive behaviours. During an interview, the Manager of Resident Care (MRC) identified that the resident continued to exhibited responsive behaviours, and the success of interventions had been limited.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 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.

A post-fall assessment for a resident was not completed in full. In an interview with a Manager of Resident Care (MRC), they confirmed the post-fall assessment was not completed as expected. The resident went to hospital, for a related injury.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

A Behavioural Supports Ontario (BSO) staff member and two Managers of Resident Care were unable to provide documentation or support showing that a re-assessment of a resident's responsive behaviours was completed.

Staff confirmed that the resident was not being followed by the BSO team, despite documentation indicating the resident continued to exhibit responsive behaviours.

Sources: The resident's clinical records; Interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

A Behavioural Supports Ontario (BSO) staff member and two Managers of Resident Care were unable to provide documentation or support, showing written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours of a resident.

Staff confirmed that the resident was not being followed by the BSO team, despite documentation indicating the resident continued to exhibit responsive behaviours. An external support resource identified that a referral to the their program had been declined in part due to the internal BSO team not being actively involved.

Sources: The resident's clinical records and the home's email communication with external support resources; Interviews with staff.

WRITTEN NOTIFICATION: Housekeeping

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

Following the occurrence of an environmental hazard, a resident's room and washroom required repair. During an observation, the resident's room, washroom, and personal belongings were noted to be dusty.

The Cleaning Standards and Frequencies St. Joseph's Health Care London outlined that a hospital cleaning following construction would include floors and baseboards to be free of construction materials, dust and gross soiling, and that horizontal surfaces including furniture, window ledges, picture frames and floors are free of visible dust in occupied areas adjacent to the construction. The document also outlines that daily cleaning of the resident's room is to be completed by housekeeping and includes high touch surfaces, horizontal surfaces including bedside table, shelves, sills, ledges, and floors.

The Environmental Service Manager confirmed the resident's room was not kept at an acceptable level of cleanliness.

Sources: Observations of the resident's room and washroom; The resident's clinical records and the Cleaning Standards and Frequencies St. Joseph's Health Care London; Interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident was not administered their prescribed medication in accordance with the directions for use specified by the prescriber.

Record review indicated that a scheduled medication was not administered as ordered. During an interview, staff confirmed the medication was missed.

Sources: The resident's clinical records; Interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #013 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1. Hold a care conference with the interdisciplinary team providing the resident's care to review all aspects of the resident’s care. Attendees must include a member of the internal Behavioural Supports Ontario (BSO) team, a Manager of Resident Care, a member of the Skin and Wound Care team, a Registered Dietitian, and any other applicable interdisciplinary team members. Ensure that the resident and the resident’s substitute decision-maker are given an opportunity to participate fully in the conference
a. Keep a documented record in the resident's PointClickCare electronic health record of the care conference that includes the date, the participants, and the results of the care conference.
b. Complete a review of the resident’s care plan following the care conference and update the care plan with any recommended changes

2. Develop and implement a process to ensure the resident’s monthly weight is obtained and documented.

3. Complete a re-assessment related to responsive behaviours exhibited by the resident to identify triggers, strategies and interventions.
a. Implement and trial techniques and interventions to prevent, minimize or respond to the responsive behaviours.
b. Re-educate all Personal Support Workers and Registered Staff on the home area who provide care for the resident on the responsive behaviours policies and procedures.
c. Maintain a documented record of how the re-education was provided, the staff educated and the date of education.

4. Ensure the resident’s refusals for specific care are documented, and reattempts

are made and documented.
a. Re-educate all Personal Support Workers (PSWs) on the home area who provide care for the resident on the PSW responsibilities specific to skin care assessments and monitoring.
b. Maintain a documented record of how the re-education was provided, the staff educated and the date of education.

Grounds

A resident was not protected from neglect when the resident demonstrated responsive behaviours that were not followed by the internal Behavioural Support Ontario (BSO) team, and when staff did not apply interventions to respond to care, or reapproach the resident to provide care.

Section 7 of Ontario Regulation 246/22 defines neglect as the failure to provide a resident with the treatment, care, services, or assistance required for their 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 identified with having a significant skin impairment requiring medical attention.

The resident was identified as having responsive behaviours. There was no evidence of documented techniques or interventions by the interdisciplinary team to prevent, minimize, respond to, or reassess the resident’s ongoing responsive behaviours. The resident was not being actively followed by the internal Behavioural Supports Ontario (BSO) team.

The resident refused care, and records did not demonstrate consistent re-approach,

alternative measures, or follow up, resulting in missed opportunities to complete required assessments or care. There was no evidence of consistent assessments despite known risk factors. The resident requested for specific care to be done, and documentation demonstrated that it was not provided or reassessed.

The resident was to receive a prescribed medication and clinical records showed the resident was not administered their prescribed medication in accordance with the directions for use specified by the prescriber. There was no documented communication with the prescriber regarding the missed medication.

Multiple referrals were made to the Registered Dietitian (RD) for specific concerns. In their assessments, the RD noted there were no weights obtained for the resident. The resident was not weighed on admission and monthly as required.

The resident did not have an annual care conference as required. Having an annual care conference would have provided an opportunity to re-assess the resident's care needs, update the care plan, assess the success of interventions and any associated risks.

Based on ongoing responsive behaviours and no active involvement from the internal BSO team, there was high risk to the resident. Despite noted refusals, there was no evidence of alternative monitoring or reassessment which led to the limited ability to identify a decline in health status. Delayed identification of a serious wound placed the resident at increased risk. The absence of interdisciplinary collaboration contributed to the unmet needs and neglect of the resident.

Sources: The resident's clinical records, the Responsive Behaviours policy, and the Skin Care and Wound Management policy; Interviews with staff.

This order must be complied with by March 24, 2026

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.