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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: October 8, 2025
Inspection Number: 2025-1397-0004
Inspection Type: Critical Incident Follow up
Licensee: St. Joseph's Health Centre of Sudbury
Long Term Care Home and City: St. Joseph's Villa, Sudbury, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 6 - 8, 2025

The following intake(s) were inspected:
- One follow-up intake related to transferring and positioning techniques; and,
- One intake regarding resident-to-resident physical abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1397-0003 related to O. Reg. 246/22, s. 40

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

Resident Care and Support Services
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the 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.

The licensee has failed to immediately report an incident of resident-to-resident physical abuse resulting in injury to the Director.

Sources: Critical incident (CI) report; the home's policy titled "Critical Incident Reporting & Review"; a non-disciplinary letter; and interview with Assistant Director of Care (ADOC).

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

The licensee has failed to ensure strategies were implemented for a resident related to responsive behaviours.

A resident was ordered to have a specific intervention to respond to their behaviours. On one occasion when the intervention was not implemented, the resident was involved in a physical altercation with a co-resident, which resulted in injury to the co-resident.

Sources: Resident health records; the home's internal investigation notes; the home's responsibilities document related to the specified intervention; and interview with ADOC.

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