

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

Hamilton District

119 King Street West, 11th Floor Hamilton, ON, L8P 4Y7 Telephone: (800) 461-7137

Public Report

Report Issue Date: March 26, 2025

Inspection Number: 2025-1411-0002

Inspection Type:Critical Incident

Licensee: St. Peter's Care Centres

Long Term Care Home and City: St. Peter's Residence at Chedoke, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 18-21, 24-26, 2025

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00132615/CI# 2927-000041-24, and intake #00140119/CI# 2927-000006-25 related to prevention of abuse
- Intake #00138007/CI# 2927-000005-25 related to falls prevention and management
- Intake #00140849/CI# 2927-000009-25 related to infection prevention and control

The following intakes were completed in this CI inspection:

 Intake #00137047/CI# 2927-000001-25, and intake #00137427/CI# 2927-000003-25 related to infection prevention and control

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

Infection Prevention and Control Prevention of Abuse and Neglect Responsive Behaviours Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 9.1 Routine and Additional Precautions, under the IPAC Standard for Long-Term Care Homes, (April 2022, revised September 2023), the licensee has failed to ensure that a staff member applied the required personal protective equipment (PPE) when in contact with a resident environment that required additional precautions.

Sources: observation, interview with staff.