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

Hamilton District
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Public Report

Report Issue Date: November 21, 2025
Inspection Number: 2025-1411-0006
Inspection Type: Complaint Critical Incident Follow up
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 date(s): November 6, 10, 12, 13, 17, 18, 19, 20, 21, 2025.

The following intake(s) were inspected:

Critical Incident (CI) Intake #00158428 related to prevention of abuse and neglect.
Complaint Intake #00160727, related to reporting and complaints, responsive behaviours, resident care and support services and medication management.
Follow-up Intake #00158785, for compliance order #001 from inspection report #2025-1411-0004 for FLTCA, 2021 s. 24 (1) Duty to protect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1411-0004 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

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

"Physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

A resident had responsive behaviours that were triggered by personal care. Interventions and strategies were developed to prevent, minimize and respond to these behaviours. The plan of care was not followed related to their individualized care needs and the resident sustained injuries.

Sources: Interviews with staff, progress notes, assessments and the homes investigation notes.