

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: September 25, 2025

Inspection Number: 2025-1411-0004

Inspection Type:

Complaint
Critical Incident

Licensee: St. Peter's Care Centres

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

INSPECTION SUMMARY

This inspection occurred onsite on the following dates: September 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, and 24, 2025.

The following intakes were inspected:

Intake: #00148301 for Critical Incident System (CIS) report #2927-000023-25 related to duty to protect.

Intake: #00150446 for a complaint related to duty to protect, continence care and bowel management, responsive behaviours, dress, and compliance with manufacturers instructions.

Intake: #00151013 for a complaint related to duty to protect, Residents' Bill of Rights, responsive behaviours, falls prevention and management and continence care and bowel management.

Intake: #00151487 for CIS report #2927-000027-25 related to falls prevention and management.

Intake: #00153045 for CIS report #2927-000031-25 related to falls prevention and management.

Intake: #00153910 for CIS report #2927-000035-25 related to infection prevention and control.

Intake: #00154016 for CIS report #2927-000036-25 related to duty to protect.

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management

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Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

A. The licensee has failed to ensure that the written plan of care for a resident set out the planned care of keeping their bedroom door closed to prevent potential altercations.

Sources: Review of progress notes and care plan, Critical Incident (CI) and interviews with the acting Director of Care (DOC) and other staff.

B. The licensee has failed to ensure that there were written plans of care for three residents that set out their planned care related to their morning routine, specifically when they were to get dressed for the day.

Sources: Observations on the night shift, review of plans of care for residents and Dress Up List, and interviews with Resident Care Supervisor (RCS) and other staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure the written plan of care for a resident provided clear direction to staff and others. There was conflicting direction related to three different interventions.

Sources: Review of the plan of care and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident, after an incident occurred where the resident sustained an injury, so that their assessments were consistent with and complemented each other.

Sources: Record review and interview with Registered Nurse (RN).

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #004 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

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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 ensure when a person had reasonable grounds to suspect abuse of a resident by another resident occurred, that the suspicion and information upon which it was based was immediately reported to the Director.

Sources: Review of the homes reporting records, clinical health records of the residents and interview with RN.

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (a)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that a residents communication and response system could be easily accessed and used at all times and could not be accessed when the resident required.

Sources: Interview with resident, progress notes and investigation records.

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (b)

Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(b) is on at all times;

The licensee has failed to ensure that a residents communication and response system

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was on at all times. The call bell was on the floor beside the resident and not plugged into wall. When the PSW reconnected the system, it repetitively rung and could not be deactivated.

Sources: Observation, interview with PSW.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 27 (6)

24-hour admission care plan

s. 27 (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 246/22, s. 27 (6).

The licensee has failed to ensure a bed alarm was provided to a resident. The resident's admission assessment stated the resident required the use of the bed alarm and it was documented that it was initiated. An incident occurred where staff should have been alerted but the alarm was not in place.

Sources: Clinical record and interviews with RN.

WRITTEN NOTIFICATION: Plan of care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.

Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

21. Sleep patterns and preferences.

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the residents' sleep patterns and preferences.

Three residents were observed sleeping fully dressed in day cloths and were confirmed to have received morning care prior to 0500 hours. There was no assessment of the residents' sleep patterns or preferences in their plan of care.

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Sources: Observations, interview with PSW, interview with RCS, residents plan of care.

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 45

Bedtime and rest routines

s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that three residents rest routines were supported and individualized to promote comfort rest and sleep.

Three residents were observed sleeping at 0510 hours and for the hour duration the inspector was on their unit. Staff confirmed morning care was completed and residents were dressed in their day cloths prior to 0500 hours.

PSWs were required to provide morning care to a minimum number of residents before shift change. The residents routines were not individualized, based on preferences and did not promote rest and sleep.

Sources: Residents plan of care, observations and interview with PSWs and RCS.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a residents individualized bowel and bladder plan

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was implemented. The resident was not toileted at their required times, based on their assessment.

Sources: Resident's care plan and continence assessment, interview with PSW.

WRITTEN NOTIFICATION: Hazardous substances

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 97

Hazardous substances

s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances, specifically bottles of Oxivir Tb, were kept inaccessible to residents at all times, when they were located on a cart in the recreation room on a home area, before they were secured by staff.

Sources: Observations and discussion with PSW.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 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 that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, with a revised date of September 2023, was complied with.

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate

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selection, application, removal, and disposal of PPE.

A resident had a sign on their door which identified they were on contact precautions and required PPE. PSW staff were observed providing care to the resident, without all the required PPE.

Sources: Observation and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of a Parainfluenza outbreak, declared by Public Health. The Director was notified 2 days later.

Sources: CI report and interview with IPAC lead.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.

Requirements relating to restraining by a physical device

s. 119 (1) Every licensee of a long-term care home shall ensure that the following

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requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee has failed to ensure that a residents physical device was applied as per the manufactures instructions.

Sources: Observation of resident, interview with PSW.

WRITTEN NOTIFICATION: Administration of Drugs

NC #015 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).

The licensee has failed to ensure that medication was provided to a resident as prescribed when it was needed for pain management.

Sources: Interview with resident, medication administration records and the homes investigation records.

COMPLIANCE ORDER CO #001 Duty to protect

NC #016 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:

- Have a discussion with the resident to identify any ongoing concerns related to care

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provided including on the night shift.

-If changes are required, implement, update the plan of care and communicate to staff.

-Maintain a record of the discussion with the resident and any changes made to the plan of care.

Grounds

A. The licensee has failed to ensure that a resident was protected from physical abuse by a co-resident.

Ontario Regulation 246/22 section 2 (1) defined physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Staff were alerted to a physical altercation between two residents when they heard yelling. Staff observed a physical altercation between the two residents and one resident sustained a minor injury.

Sources: Critical Incident Report, clinical health records and interviews with Registered Practical Nurse and other staff.

B. The licensee has failed to ensure that a resident was protected from emotional abuse and neglect by staff.

O. Reg. 246/22 s. 2 (1) defined emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

O. Reg. 246/22 s. 7 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for 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.

During an evening and into the next day a resident expressed to multiple staff on three different shifts they were having medical symptoms and required an intervention. The intervention was not provided till late morning the following day.

During the night the resident rang their call bell on more than one occasion for

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assistance. The home's internal investigation identified the resident's call bell was put out of reach and that remarks and gestures were made to the resident that were intimidating and imposed ignoring and lack of acknowledgment.

The resident shared they were very afraid and were very uncomfortable throughout the night because their medical concerns were not properly addressed.

When staff became aware of the allegation of abuse and neglect and took action, there was delay where immediate action was required.

Sources: Interview with resident and RCS, the home's investigation records, resident's plan of care, and Human Resource File.

This order must be complied with by October 31, 2025

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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

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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.