

**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

<b>Report Issue Date:</b> January 28, 2026
<b>Inspection Number:</b> 2026-1411-0001
<b>Inspection Type:</b> Critical Incident
<b>Licensee:</b> St. Peter's Care Centres
<b>Long Term Care Home and City:</b> St. Peter's Residence at Chedoke, Hamilton

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 21-23, 26-28, 2026.

The following intakes were inspected:

- Intake: #00162342, Critical Incident (CI) 2927-000046-25 was related to a rhinovirus outbreak; and,
- Intake: #00165376, CI 2927-000049-25 was related to an influenza A outbreak.

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

Infection Prevention and Control

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

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

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**Non-compliance with: FLTCA, 2021, s. 6 (9) 2.**

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

2. The outcomes of the care set out in the plan of care.

As part of symptom monitoring for the Infection Prevention and Control (IPAC) program and the residents plan of care, staff were to screen residents every day and evening shift and document the presence of any new respiratory or gastrointestinal symptoms in Point of Care (POC). A review of POC documentation for four residents showed multiple missing entries on day and evening shifts for each resident.

**Sources:** four residents' clinical records; and interviews with staff.

## **WRITTEN NOTIFICATION: Infection Prevention and Control Program**

NC #002 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).

**A.** Section 9.1 (f) of the IPAC Standard for Long-Term Care Homes specified that additional precautions shall include appropriate selection, application, removal and disposal of Personal Protective Equipment (PPE).

Two staff did not change from a surgical mask to an N95 mask prior to entering a

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resident's room on additional precautions as required by the home. A staff member twice did not follow the established order when doffing PPE after exiting a room on additional precautions.

**Sources:** observations; IPAC Standard for Long-Term Care Homes (revised September 2023), Routine Practices and Additional Precautions policy; and interviews with staff.

**B.** Section 9.1 (b) of the IPAC Standard specified that the four moments of hand hygiene included before aseptic procedures and initial resident contact.

Two staff did not perform hand hygiene while assembling lunch trays for residents in isolation under additional precautions. A staff member did not perform hand hygiene before donning PPE and after taking off a used N95 mask. Another staff member did not perform hand hygiene after putting a dirty clothing protector in the soiled laundry bin and trays on the dirty dish cart.

Two registered staff consistently did not perform hand hygiene prior to leaving their medication cart to administer medications to residents in the dining room. A few times, they also failed to perform hand hygiene when they returned to their medication cart.

**Sources:** observations; IPAC Standard for Long-Term Care Homes (revised September 2023), Hand Hygiene Program; and interviews with staff.

**C.** Sections 10.4 (h) and (i) of the IPAC Standard specified that support should be given to residents to perform hand hygiene prior to receiving meals, including residents who may have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

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Residents who were in isolation under additional precautions received lunch tray service. On two consecutive days, several residents were not offered, encouraged or supported to perform hand hygiene prior to receiving their lunch tray.

**Sources:** observations; IPAC Standard for Long-Term Care Homes (revised September 2023), Hand Hygiene Program; and interviews with staff.