

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 10, 2026
Inspection Number: 2026-1411-0002
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 date(s): February 26, 27, 2026 and March 3, 4, 5, 6, 9, 10, 2026.

The following intake(s) were inspected:

- Intake #00166361/Critical Incident (CI) #2927-000051-25 related to continence care.
- Intake #00167972/CI #2927-000004-26 related to infection prevention and control.
- Intake #00170504/CI #2927-000005-26 related to medication management.

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

- Continenence Care
- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

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.

O. Reg. 246/22 s. 7, defines 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.

A resident consumed a medication that they took from the top of a medication cart. A Personal Support Worker (PSW) intervened, took the medication away, and reported it to the Registered Practical Nurse (RPN).

The RPN put the medication in the cart but did not lock it and the medication cart was not secured during the unit's medication pass. The RPN did not assess the resident once they became aware and did not immediately contact the Registered Nurse (RN), doctor or Nurse Practitioner (NP). The RN was only informed when the PSW brought it to their attention, over an hour later.

Sources: resident's clinical records, home's investigation notes, College of Nurses of Ontario (CNO) report, Medication Incident report, SilverFox Pharmacy LTC Policy and Procedure Manual; observation of video footage; and interviews with PSW, NP and

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Director of Care (DOC).

WRITTEN NOTIFICATION: Dealing with complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(e) every date on which any response was provided to the complainant and a description of the response; and

A written and verbal complaint was made to staff at the home concerning the care of a resident. The home shared that a response was provided to the complaints after the home's investigation concluded and that action was taken related to the resident's care concerns but some documentation was missing. The home did not document every date a response was provided to the complaints or a description of what was shared.

Sources: Home's investigation records, home's complaint and Critical Incident (CI) log reports, resident's progress notes, and information provided by the home in CI.

WRITTEN NOTIFICATION: Dealing with complaints

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

Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

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(f) any response made in turn by the complainant.

A written and verbal complaint was made to staff at the home concerning the care of a resident. The home shared that a response was provided to the complaints after the home's investigation concluded but some documentation was missing. The home did not document all of the responses made in turn by the complainants.

Sources: Home's investigation records and complaint and Critical Incident (CI) log reports, resident's progress notes, and information provided by the home in CI.

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

During a medication pass, a resident consumed a medication that was left sitting on top of a medication cart. The resident did not have an order for that medication. It was prescribed to another resident in the home area.

Sources: resident's clinical records, home's investigation notes, CNO report, Medication Incident Report; observation of video footage; and interviews with DOC #106, NP #104 and PSW #101.

COMPLIANCE ORDER CO #001 Safe Storage of Drugs

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NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

- (a) drugs are stored in an area or a medication cart,
- (ii) that is secure and locked,

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

1) Perform 15 audits during separate medication passes to ensure that medications are secured and locked in the cart.

2) Ensure to completed at least one audit:

- a) in every resident home area,
- b) on every shift,
- c) on a weekend (Saturday or Sunday); and,
- d) of a casual, part-time and full-time nursing staff.

3) Audits are to be documented and include:

- a) date and time/shift,
- b) home area,
- c) person who was audited,
- d) person completing the audit; and,
- e) any corrective actions taken, if required.

Grounds

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Video footage of a home area, during medication pass, showed the medication cart was in the middle of a room, in close proximity to residents that required greater monitoring. Multiple times while the RPN was administering medications to residents, the medication cart was unlocked and the RPN had their back turned or was away from the cart.

During the medication pass a resident was seen taking a medication off of the top of the medication cart, and consuming it. A PSW intervened, took the medication away from the resident and gave it to the RPN. The RPN put it the medication cart and walked away, without locking it.

Failure to keep medication secured and locked inside the cart, resulted in a resident accessing and ingesting unprescribed medication, which resulted in a change in condition requiring intervention. Failure to keep the medication cart locked during medication pass put all residents in the home area at risk.

Sources: resident's clinical records, home's investigation notes, CNO report, Medication Incident report, Medication Administration Standards; observations of video footage; and interviews with DOC, NP and PSW.

This order must be complied with by April 24, 2026.

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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

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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

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:

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
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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.