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

Public Report

Report Issue Date: March 5, 2025

Inspection Number: 2025-1458-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: St. Joseph's Health System

Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3, 5-7, 10-12, 14, 18, 2025.
The inspection occurred offsite on the following date(s): February 4 and 13, 2025.

The following intake(s) were inspected:

- Intake: #00128591 – Critical Incident (CI) #2975-000090-24 - related to prevention of abuse and neglect.
- Intake: #00129718 – CI #2975-000093-24 - related to falls prevention and management program.
- Intake: #00130682 – CI #2975-000094-24 - related to prevention of abuse and neglect.
- Intake: #00134596 – CI #2975-000099-24 - related to resident care and support services.
- Intake: #00136092 – CI# 2975-000003-25 - related to infection prevention and control (IPAC).
- Intake: #00133324 – complaint related to prevention of abuse and neglect, laundry services, plan of care, religious and spiritual practices, and complaints.

- Intake: #00134654 – complaint related to prevention of abuse and neglect, resident care and support services, and maintenance services.
- Intake: #00138235 - Follow-up to Compliance Order (CO) #001 from inspection #2025_1458_0001, Ontario Regulation (O. Reg) 246/22 - s. 19 Windows, Compliance Due Date (CDD) January 31, 2025.

The following intakes were completed:

- Intake: #00137128 – CI #2975-000007-25 - related to falls prevention and management program.
- Intake: #00137417 – CI #2975-000008-25 - related to IPAC.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2025-1458-0001 related to O. Reg. 246/22, s. 19

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 call bell pull station beside the bathtub in an identified tub room could be easily used at all times. The pull station was found in poor repair, leaving it difficult to engage the resident-staff communication and response system.

The pull station was immediately replaced and found in good working order on February 6, 2025.

Sources: Observations and interviews.

Date Remedy Implemented: February 6, 2025

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff involved in a resident's care collaborated and created a consistent plan of care related to falls prevention and management.

A resident was added to the home's Falling Leaf program List over a specified period as they met the criteria for the program; however, their plan of care did not consistently reflect the Falling Leaf program as being an active intervention during the same period.

Sources: Interviews with staff, a resident's clinical record, home's policy "Falls Prevention and Management Program", Falling Leaf Program List.

WRITTEN NOTIFICATION: Resident Care and Support

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was contacted when the resident had a change in condition and increase in care needs. Failure to contact the SDM prevented them from participating in the development and implementation of the resident's plan of care.

Sources: A resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure that the care set out in a resident's plan of care was documented as required specific to the use of a personal assistance services device (PASD) and food and fluid intake.

Sources: Policies, interviews with staff, a resident's clinical record.

B) The licensee has failed to ensure that the care set out in a resident's plan of care was documented as required specific to the type and level of assistance provided for transfers and toileting.

Sources: A resident's clinical record.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the

policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse was followed when staff failed to accurately document a report of alleged abuse and what actions were taken in response to the report.

Sources: The home's policy "Prevention of Abuse and Neglect of a Resident", interviews, a resident's clinical record.

WRITTEN NOTIFICATION: Windows

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Compliance order (CO) #001 from inspection #2025_1458_0001 issued on January 27, 2025, with a compliance due date (CDD) of January 31, 2025, to O. Reg. 246/22 s. 19 was not complied with.

The following components of the order were not complied:

1. Audit all windows, in the long-term care home, that are accessible by residents to ensure that the window opening cannot open more than 15 centimeters, and that each window is equipped with an intact screen if the window can open to the outside. The audit and all work must be completed within five business days of the licensee receiving the Inspection Report. The audit must be documented, and include the date the audit was completed, room numbers, number of windows and screens in the room, any deficiency identified, corrective action taken and who completed the work.

2. Documentation of the audit and corrective action taken, if any, are to be kept and made immediately available to an Inspector upon request.

The licensee has failed to complete an audit of all windows in the home that were accessible to residents, that included room numbers, the number of windows and screens in each room, any deficiencies identified, and corrective action taken. There were windows in the home that were not on the audit. There were deficiencies observed including screens that were not intact and a window that opened more than 15 centimeters in resident accessible areas, that were not captured on the audit.

Sources: The home's window audit, observations of windows in resident accessible areas, interview with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #006

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
O. Reg 246/22 s. 19 was issued as CO on January 27, 2025 (#2025_1458_0001) with a CDD of January 31, 2025.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Safe and Secure Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff. During the inspection, a medication room, laundry room, and clean and soiled utility room were left open with no staff visibly available to supervise.

Sources: Observations, interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's falls prevention and management program when they did not assess a resident for pain when indicated and did not refer the resident to interdisciplinary risk rounds when they had a higher frequency of falls.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure written policies developed for the falls prevention and management program are complied with.

Specifically, the home's falls policy indicated that staff were to implement the 4P's approach, which included assessing pain when addressing potential contributing factors for falls, and refer residents at high risk for falls to interdisciplinary risk rounds.

Sources: Interviews, a resident's clinical record, the home's policy "Falls Prevention and Management Program".

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #009 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 standard or protocol issued by the Director with respect to infection prevention and control specifically to hand hygiene, was implemented when a staff failed to remove gloves and perform hand hygiene after discarding soiled linen.

Sources: Observation, the home's hand hygiene policy, training records, interviews.

COMPLIANCE ORDER CO #001 Emergency plans

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 90 (1) (a)
Emergency plans
s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Ensure a specified staff is familiar with requirements relevant to the home's code

blue policy and how to mitigate through a medical emergency.
2. Ensure education provided to the specified staff is documented, including their name, designation, date, time and person who provided the education. Ensure records are available for inspector review.

Grounds

The licensee has failed to ensure that they complied with emergency plans in place when staff did not follow requirements set out in the home's code blue policy when responding to a non-responsive resident.

Sources: The home's code blue policy, interview with staff, other records.

This order must be complied with by April 11, 2025

COMPLIANCE ORDER CO #002 Accommodation services

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Ensure that windows and screens in two resident rooms, the café and lounge are maintained in a good state of repair.
2. Develop and implement a program that includes the good repair of all windows and screens.
3. The person responsible for ensuring all actions are complete.

Grounds

The licensee has failed to ensure that all windows and screens that opened to the outdoors and were accessible to residents were maintained in a good state of repair. A screen in a resident's room had a rip in it, a window in the café area and another window in the lounge, on the first floor had screens that were falling down. A window in a resident's room could not be closed properly, which was allowing cold air to enter the home. The outside temperature at the time of observations was between -6.1 degrees Celsius to -8.8 degrees Celsius.

Failure to ensure that windows were in good repair caused discomfort and placed residents' safety at risk.

Sources: Observations, interview.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #003 Duty to protect

NC #012 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:
1. Conduct an analysis of the incident of neglect.
2. Evaluate the results of the analysis.
3. Determine changes or improvements that are required as a result of the analysis.

4. Implement changes or improvements.
5. Maintain a written record of the results of the analysis, the changes or improvements that were identified and how they were implemented.

Grounds

A) The licensee has failed to ensure that a resident was not neglected by staff.

O. Reg. 246/22 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.

On an identified date, staff failed to provide a resident with the assistance they required for safety. A device that was required to be accessible and in good working order at the time of the incident was in poor repair, which staff had already been aware of. No maintenance request had been submitted to repair the device.

Failure to provide the resident the care they required for their health, safety and well-being put them at increased risk of harm.

Sources: Interviews, maintenance log, a resident's care plan.

B) The licensee of a long-term care home has failed to protect residents from physical abuse by co-residents.

O. Reg. 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

i) On an identified date, an incident occurred where a resident sustained physical injury as a result of physical force used by a co-resident.

ii) On a second identified date, an incident occurred where a resident sustained physical injury as a result of physical force used by a co-resident.

Sources: residents clinical records, interviews with staff.

This order must be complied with by April 14, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
FLTCA 2021, s. 24 (1) was issued as a CO on May 21, 2024 (#2024_1458_0002).
FLTCA 2021, s. 24 (1) was issued as a WN on October 31, 2024 (#2024_1458_0004), August 23, 2024 (#2024_1458_0003), October 24, 2023 (2023_1458_0005) and August 17, 2023 (#2023_1458_0004).

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #004 Maintenance services

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

1. Develop and implement schedules and procedures for preventative maintenance of the resident-staff communication and response system at every communally located toilet used by residents, every bath and shower location used by residents, and every common area accessible by residents within the home.

2. Audit all resident-staff communication and response system point of activation stations located in the home at every communally located toilet, bath and shower locations used by residents and every common area accessible by residents to ensure they can be easily seen, accessed and used by residents, staff and visitors at all times. Auditing is not required for point of activation stations located at each resident bed and toilets located inside resident rooms.

3. The audit must be documented and include the date(s) the audit was completed, the location(s) of the point of activation station audited, any deficiency identified and corrective action(s) taken, and the name(s) of the staff who completed the audit.

4. Documentation required for this compliance order shall be kept and made immediately available to an Inspector upon request.

Grounds

The licensee has failed to ensure that schedules and procedures were in place for preventative maintenance of the resident-staff communication and response system in the home for call bell point of activation stations in common areas, including, but not limited to tub rooms, shower rooms and common areas.

Failure to have preventative maintenance processes in place increased potential risk to the safety and well-being of residents in the home.

Sources: Preventative maintenance work orders, interviews with staff.

This order must be complied with by April 14, 2025

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

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.