

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: December 12, 2025

Inspection Number: 2025-1458-0009

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): November 19 - 21, 24, 26 - 28, 2025 and December 1 - 5, 8 -12, 2025

The following intake(s) were inspected:

-Intake: #00154163 - Follow-up #: 1 - O. Reg. 246/22 - s. 23.1 (3) 1. CDD 2025-10-23.

-Intake: #00159648 - Complaint with concerns regarding resident 's Plan of care, continence care and bowel management, Skin and wound prevention and management, Infection prevention and control program, Food hydration and Nutrition, Prevention of abuse and Neglect.

-Intake: #00161327 - Complaint with concerns regarding resident's, Plan of care, Skin and wound prevention and management, Responsive behaviours.

-Intake: #00163740 - Critical incident (CI) 2975-000068-25 - Prevention of abuse and Neglect.

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Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1458-0005 related to O. Reg. 246/22, s. 23.1 (3)
1.

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

- Skin and Wound Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Food, Nutrition and Hydration
- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours

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. 102 (2) (b)

Infection prevention and control program

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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 standard or protocol issued by the Director with respect to infection prevention and control was not complied with on a set date, when there was no droplet precaution signage in front of droplet isolation room.

Remedied taken before conclusion of the inspection:

Droplet precautions signage was placed in front of the resident door on the same day.

Sources: Observations, Interview with staff.

Date Remedy Implemented: November 27, 2025

WRITTEN NOTIFICATION: Duty to Protect

NC #002 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.

A resident was not protected from physical abuse when a staff member used force that caused pain.

Sources: Interview with the staff and complainant, record reviews.

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WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #003 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 did not ensure that their policy to promote zero tolerance of abuse and neglect of a residents was complied with, on a set date, when a staff member did not follow the policy of immediately assessing the resident; after a reported incident of abuse involving a resident.

Sources: Resident's clinical records and other records, interview with complainant and staff.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

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A resident's plan of care, as it related to the strategies for managing the resident, was not implemented by staff when a staff physically abused a resident. This response was not consistent with the interventions and strategies outlined in the resident's plan of care, since the plan of care identified specific approaches to safely and respectfully manage the resident.

Sources: Review of observation, review of resident's clinical records.

WRITTEN NOTIFICATION: Maintenance services

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

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 home's process to ensure that schedules and procedures were in place for routine, preventive and remedial maintenance for the temperature control valve was not complied with when the preventative maintenance (pm) task did not include the temperature control valves and the home did not follow up to remediate the issue causing the temperature fluctuations.

Sources: Temperature logs, interview with staff, work orders, preventative maintenance task list.

WRITTEN NOTIFICATION: Infection prevention and control

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program

NC #006 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 standard or protocol issued by the Director with respect to infection prevention and control was not complied with on a set date, when staff provided care to a resident in a contact isolation room and did not perform hand hygiene after exiting the resident's room. Another staff did not remove their gloves after bagging dirty linen from the contact isolation room and did not perform hand hygiene.

Sources: Observation, Interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #007 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).

On a set date, a staff member administered another resident's medication to a resident which had not been prescribed for that Resident.

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Sources: Clinical records for resident, medication incident report, interview with staff and complainant.

WRITTEN NOTIFICATION: Administration of drugs

NC #008 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).

On a set date, during medication administration, it was discovered that a medication was missing, which had resulted from the wrong medication being administered. Staff did not follow the proper steps to verify the medication before administering the medication.

Sources: Progress notes, medication administration record (MAR), medication incident report, interview with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

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

Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon,

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every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

On a set date, when staff identified a missing medication, they did not maintain a record of the medication incident, together with the immediate actions to assess and maintain the resident's health.

Sources: Progress notes, interview with staff.

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee must:

1) Report to the Director, in accordance with FLTCA s.28(1), all incidents from the past six months, that have not been previously reported, where anyone had reasonable grounds to suspect that a resident was abused and that the resident

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experienced harm or was at risk of harm.

2) Keep a record of all incidents that were identified and previously not reported, for the inspector to review.

3) Review the Home's internal processes and procedures related to reporting certain matters to the Director, specifically abuse, and update to ensure alignment with the Fixing Long-Term Care Act, 2021, and the associated Regulation.

4) Provide training on reporting certain matters to the Director to all management staff, including the Director of Care and any staff responsible for receiving, reviewing, or reporting incidents of abuse, to ensure they understand the current legislative requirements for mandatory reporting, and your Home's policy, and procedures if applicable.

5) Keep a record for the Inspector to review, including:

- a) A record of the training delivered,
- b) the dates,
- c) staff in attendance,
- d) and content covered.

Grounds

The home had reasonable grounds to suspect a resident was abused, resulting in harm or a risk of harm, and did not immediately report the incident to the Director as required. The incident was reported late, after it was identified by the inspector.

Sources: Review of residents clinical records, other records, interviews with complainant and staff.



**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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This order must be complied with by February 27, 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.