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: April 22, 2026
Inspection Number: 2026-1458-0003
Inspection Type: Critical Incident
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): April 8 - 10, 13, 14 - 17, 20 - 22, 2026

The following critical incidents (CI) intake(s) were inspected:
-Intake: #00166140/ CI #2975-000078-25 - relating to falls prevention and management.
-Intake: #00167018/ CI #2975-000001-26 - relating to falls prevention and management
-Intake: #00167555/ CI #2975-000003-26 - infection prevention and control
-Intake: #00167788/ CI #2975-000004-26 - infection prevention and control
-Intake: #00168242/ CI #2975-000008-26 - infection and prevention and control
-Intake: #00169994/ CI #2975-000012-26 - relating to food, nutrition and hydration
-Intake: #00170928/ CI #2975-000015-26 - relating to falls prevention and management

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

Food, Nutrition and Hydration

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's falls policy indicated that resident's who were at a high risk of falls would be placed in the Falling Leaf Program and that the Falling Leaf Symbol would be placed on the resident's mobility aid and room name plate. A resident was indicated to be a high risk of falls and on the Falling Leaf Program, however the Falling Leaf Symbol was not found on the residents mobility aid or room name plate.

Sources: Resident's clinical records, observations, the home's Falls Policy, and interviews with staff.

WRITTEN NOTIFICATION: Pain management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A staff administered a PRN medication to a resident for their pain. The PRN was ineffective and the resident's pain level was still present. The nurse did not complete an assessment for the resident's pain.

Sources: Progress notes, Pain Policy and interview with ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

A resident exhibited symptoms of infection on a specific date in January 2026 and was isolated. Symptom documentation was not completed on multiple dates while the resident remained isolated and symptomatic.

Sources: Resident's clinical record, policy, interview with Infection Prevention and Control (IPAC) Leads.

A resident exhibited symptoms of infection in January 2026 and was isolated. Symptom documentation was not completed on multiple dates while the resident remained symptomatic.

Sources: Resident's clinical record, policy, interview with Infection Prevention and Control (IPAC) Leads.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Discuss the gaps in hand hygiene and personal protective equipment (PPE) that occurred on April 13, 2026 with staff and review the correct IPAC actions.
2. Maintain a written record of the discussions with each staff member, including who conducted the review, date the review occurred and signature of each staff.
3. Conduct a one-time audit of all resident rooms for residents isolated for respiratory symptoms to ensure the appropriate precaution signage is posted in

accordance with the home's respiratory illness policy.
4. Maintain a written record of the audit, including the date the audit was conducted, staff name(s) who completed the audit and any corrective actions taken as a result.

Grounds

A) In accordance with Additional Requirement 4.3 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022, revised February 2026), the interdisciplinary IPAC team were to be included in the debrief session following resolution of an outbreak. The home's process for conducting a debrief session did not include the Administrator, Medical Director or designate for the local medical officer of health as required under Ontario Regulation 246/22 section (s) 102 (4) (b) and (d).

Sources: Debrief record for outbreak critical incidents.

B) In accordance with Additional Requirement 9.1 under the IPAC Standard, routine practices were to be followed, including b) hand hygiene before and after resident/resident environment contact, and after body fluid exposure risk. A staff entered and exited a resident's room on two occasions. The resident was demonstrating symptoms of infection and additional precautions were in place at the time. A staff entered resident's room on both occasions without sanitizing their hands, was observed within two (2) meters (m) of the resident assisting a resident in the washroom, touching the washroom door and wheelchair handles, then exiting the room and attending to other residents without performing hand hygiene.

There was a significant risk of infectious disease transmission and a risk to resident health when staff did not perform hand hygiene.

Sources: Observations conducted on Rose Garden home area, line list for outbreak.

C) In accordance with Additional Requirement 9.1 under the IPAC Standard, additional precautions were to be followed, including j) point-of-care signage indicating enhanced IPAC control measures were in place. Observations were conducted on two home areas, both which were in confirmed respiratory outbreaks.

On one home area unit multiple resident room's had personal protective equipment (PPE) bags in place; however, no point-of-care signage to direct staff on required enhanced IPAC measures. The residents were isolated for multiple respiratory symptoms and met the case definition for acute respiratory infection. The Inspector brought forward these observations to the staff on the home area and the home's IPAC Leads. On April 15, 2026, the Infection Control Practitioner from the Hamilton Niagara Haldimand Brant Hub conducted observations on the same home area unit, and noted missing and incorrect IPAC signage on isolated resident doorways.

Further, on another home area unit, a resident's room had IPAC signage on the door indicating droplet contact precautions were in place. Review of the outbreak line list and the resident's clinical record indicated that the resident was to have contact precautions in place.

A resident's room had a PPE bag in place and no IPAC signage. The resident was exhibiting respiratory symptoms and to be in isolation on the date of the observation. Signage was observed to be posted on the door of the resident's room later that same day after the Inspector brought forward their observation to staff.

When point-of-care IPAC signage was not posted as required, staff and others entering the rooms did not have clear direction, which increased the risk of improper PPE use and infection transmission.

Sources: Observations on home areas, resident's clinical records, line list for outbreak, IPAC Hub report, policy, email communication with IPAC Leads.

D) In accordance with Additional Requirement 9.1 under the IPAC Standard, additional precautions were to be followed, including k) appropriate PPE selection, application and removal. On a specific date in April, the following observations were made on a two different home areas, which were in seasonal coronavirus and rhinovirus/enterovirus outbreaks respectively.

i) A staff was observed in a resident's room within 2m of the resident, who was symptomatic and isolated for suspected respiratory infection. The staff was wearing a medical mask and was to be wearing eye protection, gloves and a gown in accordance with the droplet contact precautions in place. The medical mask was not removed and replaced with a new medical mask upon exiting the resident's room.

ii) A staff was assisting a resident in their shared room washroom, wearing a medical mask and gloves. Both residents in the shared room were on isolation for suspected respiratory infections and droplet contact precautions were in place. The PSW did not remove the medical mask upon exiting the room.

iii) A staff entered and exited a resident's room on two occasions wearing only a medical mask, while the resident was in the washroom with another staff. The staff was within 2m of the symptomatic resident on both occasions. They did not remove their medical mask upon exiting the room.

iv) A staff exited a resident's room, doffed their PPE in the incorrect order: face shield, gown, then gloves, and did not replace their medical mask with a new mask.

The resident was symptomatic and isolated for suspected infection.

v) A staff entered a resident's room to complete tasks while the resident was in the room, wearing gloves and a medical mask. Droplet contact precaution signage was on the doorway at the time.

There was a significant risk of infectious disease transmission and a risk to resident health when staff did not follow appropriate PPE donning and doffing expectations during multiple confirmed outbreaks.

Sources: Observations on home areas, line list for outbreak, email communication with IPAC Leads, interview with staff.

This order must be complied with by May 5, 2026

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

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.