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: May 16, 2025
Inspection Number: 2025-1265-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: The Central Canadian District of the Christian and Missionary Alliance in Canada
Long Term Care Home and City: CAMA Woodlands Nursing Home, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 28-30, May 1, 14-16, 2025.

The following intake(s) were inspected:

- Intake: #00138602 - Follow-up to Compliance Order (CO) #001/2025-1265-0001, O. Reg. 246/22 - s. 272 regarding recommendations issued by the Chief Medical Officer of Health, Compliance Due Date April 25, 2025.
- Intake: #00139134 - Critical Incident (CI) #2774-000002-25 related to Prevention of Abuse and Neglect and Responsive Behaviours.
- Intake: #00144131 - CI 2774-000004-25 - related to Prevention of Abuse and Neglect and Responsive Behaviours.
- Intake: #00144358 - Complaint related to Residents' Rights.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1265-0001 related to O. Reg. 246/22, s. 272

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and

The licensee has failed to ensure that a resident's right to participate fully in making decisions was fully respected and promoted. Actions taken regarding a resident was not based on an assessment of the resident nor was there documentation that showed the resident was given opportunity to fully participate in the decision.

Sources: Resident records, interviews.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that a resident's written plan of care set out their planned care regarding responsive behaviours. The resident's planned care was documented in progress notes but was not included in their written plan of care.

Sources: Resident records.

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 (2) (g)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents complied with requirements on reporting matters to the Director. The policy did not contain correct instruction on how to notify the Director immediately during business hours and after hours. Instruction as to when Critical Incident (CI) Reports were to be submitted to the

Director also did not comply with reporting requirements.

Sources: The home's Abuse Policy, ADM-01-00-01, revised November 27, 2025.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that staff who had reasonable grounds to suspect an incident of abuse of a resident was immediately reported to the Director.

Sources: Resident records, CI Report.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken with respect to a resident under

the recreational and social activities program was documented, including actions taken by staff and the resident's response to those actions.

Sources: Resident records, interviews.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that interventions were implemented to minimize the risk of altercations and potentially harmful interactions between two residents. Failure to implement the interventions contributed to altercations between the residents.

Sources: Residents records, interviews.

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