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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 5, 2025
Original Report Issue Date: October 4, 2024
Inspection Number: 2024-1551-0004 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Corporation of the City of Cornwall
Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order #006 from 2023-1551-0003, related to FLTCA, s. 6 (7) issued on August 14, 2023, was amended on April 29, 2025, to include an AMP that was not previously issued.

Compliance Order #004 was amended on May 15, 2025, to amend an AMP due to administrative changes.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report (A1)

Amended Report Issue Date: June 5, 2025
Original Report Issue Date: October 4, 2024
Inspection Number: 2024-1551-0004 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Corporation of the City of Cornwall
Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order #006 from 2023-1551-0003, related to FLTCA, s. 6 (7) issued on August 14, 2023, was amended on April 29, 2025, to include an AMP that was not previously issued.

Compliance Order #004 was amended on May 15, 2025, to amend an AMP due to administrative changes.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 5, 8, 9, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 29, 30, 31, 2024 and August 1, 2, 2024
The inspection occurred offsite on the following date(s): August 2, 2024

The following intake(s) were inspected:

Critical Incident System Report (CI)
• Intakes #00018996 (CI #M529-000006-23), #00109374 (CI #M529-000013-24), #00112198 (CI #M529-000018-24), #00113099 (CI #M529-000022-24), #00113316 (CI #M529-000024-24), #00113664 (CI #M529-000025-24), #00114040 (CI #M529-000027-24), #00118964 (CI #M529-000036-24), #00119112 (CI #M529-000037-24), #00119115 (CI #M529-000038-24), #00121093 (CI #M529-000052-24) - relating to allegations of staff to resident neglect
• Intakes #00109126 (CI #M529-000011-24), #00109462 (CI #M529-000014-24), #00119775 (CI #M529-000042-24) - relating to allegations of resident to resident physical abuse
• Intakes #00109281 (CI #M529-000012-24), #00113039 (CI #M529-000020-24) - relating to allegations of improper care of a resident
• Intakes #00111625 (CI #M529-000017-24), #00119276 (CI #M529-000040-24) - related to missing residents

Complaint
• Intake: #00108890 - A complaint with multiple care concerns
• Intake: #00113102 - A complaint with concerns regarding an allegation of staff to resident physical abuse
• Intake: #00114183 - A complaint with concerns regarding an allegation of staff to resident verbal abuse

Follow-up
• Intake: #00114999 - Follow-up #1 - High Priority CO #001 / 2024-1551-0001, FLTCA, 2021, s. 6 (10) (c) regarding reassessment of the plan of care

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1551-0001 related to FLTCA, 2021, s. 6 (10) (c)

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
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 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.

1) The licensee has failed to ensure that the provision of care set out in a resident's responsive behaviour plan of care, specifically Q 15 minute safety checks were being documented.

Sources: Review of the Q 15 minute - Safety Checks on point click care Tasks and interview with a Personal Support Worker (PSW) and other staff.

2) The licensee has failed to ensure that the care set out in the plan of care for a resident was documented. Specifically, monitoring of the resident's safety device was not documented on eleven night shifts in a specific month, and monitoring of safety checks and of fall risk was not documented on eight night shifts in a specific month.

Sources: Point of Care documentation, interviews with a PSW and the Interim Director of Care (DOC).

3) The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented which identified that the resident should be turned and repositioned every two hours. This documentation was not completed as per the plan of care on one day when the resident was left unattended for four hours.

Sources: Point of Care documentation.

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the tiles on the floor were maintained in a safe condition and in a good state of repair.

Sources: Inspectors' observation. Interview with Support Services Supervisor.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that appropriate action was taken in response to an allegation of resident neglect when the resident was left unsupervised during a personal care activity.

Sources: Staff schedule, investigation notes, Interviews with two PSW's and the Deputy Administrator.

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

1) The licensee has failed to immediately report to the Director an incident that related to improper treatment that resulted in a risk of harm to a resident. It was submitted the next day.

Sources: Critical Incident Report and an interview with the Operations Deputy Administrator.

2) The licensee has failed to immediately report to the Director an incident that related to improper treatment throughout a shift which resulted in a risk of harm to a resident. It was submitted the following day.

Sources: Critical Incident Report and an interview with the Interim DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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.

1) The licensee has failed to ensure that an incident of resident to resident physical abuse was immediately reported to the Director.

Sources: Review of the afterhours reporting system, Critical Incident System report (CIS), and an interview with the interim DOC.

2) The licensee has failed to ensure that an incident of alleged staff to resident neglect was immediately reported to the Director.

Sources: Review of Critical Incident System report, emails, and interview with a Registered Practical Nurse (RPN) and the PSW Supervisor.

WRITTEN NOTIFICATION: Positioning Aids

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that procedures were implemented to ensure that a resident's wheelchair head rest were kept in good repair for safe repositioning.

Sources: Inspector's observation. Interviews with a PSW and a Physiotherapist.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 infection prevention and control (IPAC) standard issued by the Director, specifically standard 9.1 related to the hand hygiene, was followed by a PSW during morning snack services.

Sources: Inspector's observation. Interview with a PSW.

WRITTEN NOTIFICATION: Abuse and Neglect Policy

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or

neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations.

The licensee has failed to ensure that the home's written policy under section 25 of the Act titled Zero Tolerance of Resident Abuse and Neglect Program:
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.

The Administrator acknowledged that the home's Zero Tolerance of Resident Abuse and Neglect Program was not compliant with the subsections (a) (b) and (d) of the legislation.

Sources: Zero Tolerance of Resident Abuse and Neglect Program, Interview with the Administrator.

WRITTEN NOTIFICATION: Notification re incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that an incident of resident to resident physical abuse was immediately reported to one of the resident's Substitute Decision Maker.

Sources: Review of the Critical Incident System report and an interview with the PSW Supervisor and other staff.

WRITTEN NOTIFICATION: Evaluation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee has failed to ensure that at least once in the 2023 calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 25 of the Act titled Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, and what changes and improvements were required to prevent further occurrences of abuse and neglect.

Sources: The home's CIS spreadsheet and the Administrator's interview.

COMPLIANCE ORDER CO #001 Duty to protect

NC #011 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:
A) Review and revise the process for investigating allegations of abuse and the actions taken once an allegation of staff-to-resident abuse is received. The process should contain the actions taken to ensure residents are protected from abuse and neglect during the investigation process.
B) Provide training to all Managers and Supervisors of the investigation process, including the process for protecting residents from staff-to-resident abuse.
C) Provide training to the staff providing assistance with transfer for two residents. The training will include the two resident's plan of care regarding transfer assistance status and supervision when using the toilet, and safe transfer and positioning techniques specific to the two residents.

A written record will be kept of everything required under sections (A), (B) and (C), until the Ministry of Long-Term Care complies this order.

Grounds
1) The licensee has failed to ensure that a resident was not neglected by a PSW.

"Neglect" means 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.

The PSW left the resident unattended and attached to the mechanical lift during a personal care activity for a period of time. The resident was found to have experienced negative effects. The resident's plan of care directs staff to remain with the resident at all times during this care task.

Sources: CIS report, home's investigation. Interviews with the PSW and the Interim DOC.

2) The licensee has failed to protect a resident from neglect by two PSWs.

For the purposes of the Act and this Regulation, "neglect" means 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.

The two PSWs left the resident unsupervised and attached to the mechanical lift during a personal care activity. The lack of the PSWs supervision during this

personal care activity contributed in the resident experiencing a negative effect.

Sources: Resident health record, progress notes, plan of care, the home's investigation. Interview with PSWs and an RPN.

3) The licensee has failed to ensure that a resident of the home were protected from abuse by a Personal Support Worker (PSW).

"Physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident's Substitute Decision Maker (SDM) made an allegation of abuse for care provided by a PSW. On this shift, personal care was initiated and the resident verbally refused care and expressed pain during periods the care was being completed. The two staff members did not stop the care, they did not try to reapproach the resident and they did not seek assessment from the registered staff for the resident's pain. Following the personal care being completed, the PSW did not report the resident's pain to the registered staff and instead reported that the resident was resistive to care which video footage identified was not what had occurred. The Nursing Supervisor/Interim Director of Care (DOC) spoke with the SDM on the day of the allegation and started an internal investigation. The SDM made an allegation of neglect the following day for a lack of supervision in which the same PSW was again assigned to care for the resident. The PSW again worked the following shift on the same resident home area.

Three days after the initial allegation of abuse, the PSW was informed of the allegations of abuse and neglect and interviewed by the Nursing Supervisor/Interim DOC for the purpose of the internal investigation. The PSW was then moved to work on another resident home area while the internal investigation was being completed

where they provided personal care to residents without another staff member present and without any instruction to the registered staff regarding supervision of the PSW. The Nursing Supervisor/Interim DOC stated the internal investigation was completed and significant corrective action was identified for the PSW to complete. Despite this, the PSW continued to work with residents unsupervised until they completed the corrective action ten days later as the DOC stated they had to organize for the replacement of the PSW's shift.

Sources: Video footage provided by the SDM, Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, staffing schedules, Critical Incidents, internal investigation documents, and interviews with Registered Nurses and the Nursing Supervisor/Interim DOC.

This order must be complied with by November 8, 2024

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director.

COMPLIANCE ORDER CO #002 Home to be safe, secure environment

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order []:
The licensee shall:

A) Conduct a thorough analysis of the front door access control system and roam alert system to identify how a resident managed to bypass them.
B) Based on the analysis, develop potential corrective actions to address vulnerabilities in the front door security systems.
C) Trial potential corrective actions as necessary and implement permanent solutions to prevent future occurrences, ensuring that no resident can bypass the front door security systems again.
D) Review and update the written procedure (Door Surveillance and Secure Outdoor Areas) for responding to front door alarms to ensure it includes clear direction to staff as to their specific roles and responsibilities in this matter.
E) Provide education and review with all staff on the licensee's written procedure for responding to front door alarms. Document how and when this education was provided, who provided the education and all staff that received the education.
F) Conduct an audit once a week on each of the three shifts for a period of four weeks, to verify that staff respond to a front door alarm as per the licensee's expectations.

Maintain documentation to support all of the actions taken with regards to (A) through (F).

Grounds
The licensee has failed to ensure the home is a safe and secure environment for its residents in that:

- A resident was able to pull open the front door and exit the building, bypassing a roam alert system and the door access control system without staff knowledge.
- At the time of the inspection, it was determined that there had been no analysis to determine how the resident was able to bypass the two security systems in place

and open the door, which is to be kept closed, locked and alarmed at all times.
- The home did not complete an analysis of the front doors locking system as a result of the incident and therefore, no actions were taken to prevent another resident from bypassing the front door security system in the way that the resident did.
- Observations at the front door, and interviews, identified knowledge gaps in the nursing and dietary departments that staff were unaware or unable to identify front door alarms while working on the nearest resident home area or the expectations in regard to when and who was responsible for responding to front door alarms.

Sources: Observations of door safety systems and functionality, observations of front door alarm enunciator panel(s) on care units. Records: resident health care record, investigation notes (critical incident), policy "Door Surveillance and Secure Outdoor Areas". Interviews with a PSW, an RPN, a Registered Nurse (RN), two dietary staff, the Support Services Supervisor, the Nutrition Services Supervisor, the Interim Director of Care, and the Interim Assistant Deputy Administrator of Operations.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #003 Plan of care

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall;
A) Develop and implement a process for communication between recreation and nursing staff as to location of residents so that all aspects of the resident plan of care is integrated and maintained.
B) Educate relevant staff on the new process. Maintain records which include identified staff and the person(s) who provided education.
C) Audit process twice weekly for four weeks to ensure consistent compliance is achieved.
D) Take remedial corrective action with staff for identified non-compliance of new process and document.

A written record will be kept of everything required under sections (A), (B), (C), and (D) until the Ministry of Long-Term Care complies this order.

Grounds

1) The licensee has failed to collaborate between nursing and recreation staff with the implementation of a resident's plan of care in respect to attending activities. The resident was left by recreation staff post activities, resulting in the resident being unaccounted for five hours. This prevented aspects of the plan of care to be integrated and consistent to meet the care requirements of the resident on this specific day.

Sources: Resident health care records and interviews with Recreation staff, a PSW, and a RN.

2) The licensee has failed to collaborate between nursing and recreation staff with the implementation of a resident's plan of care in respect to attending activities. Post attending activities, recreation staff did not inform the unit nursing staff they had returned the resident at the elevators just outside of the main resident home area.

The resident re-entered the elevator independently. The lack of communication between recreation and nursing staff resulted in the resident being unaccounted for approximately three hours, until nursing staff later located them inside the elevator. This prevented aspects of the plan of care to be integrated and consistent to meet the needs of the resident.

Sources: Observations of resident in room and communication board outside of unit elevators confirmed by an RN, resident health care records, investigation notes, and interviews with Recreation staff, a PSW, and a RN.

This order must be complied with by December 6, 2024

A1)
The following AMP(s) related to CO #004 has been amended: AMP #001

COMPLIANCE ORDER CO #004 Plan of care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Ensure the Personal Support Worker (PSW) completes a review of the resident's

plan of care for responsive behaviours. A documented record will be kept that identifies the PSW and the date that the plan of care was reviewed.
B) Complete a review of the two residents plans of care for safety checks and make any required updates to meet the needs of the residents.
C) Complete a review of the resident's plan of care regarding turning and repositioning and make any required updates to meet the needs of the resident.
D) For a period of one week, the plans of care for four residents will be reviewed at each shift change report. A documented record will be kept that identifies the staff member names and dates that the plan of care was reviewed.
E) Complete an audit daily on at least one shift to ensure the residents plans of care are provided as per the plan of care. The audits shall be completed on the day, evening and night shift each week, and shall continue for four weeks to ensure consistent compliance is achieved.
F) If deviations from the resident's plan of care are identified during the audits, immediate corrective action shall be taken.

A record must be kept of everything required under (A), (B), (C), (D), (E), and (F), until the Ministry of Long-Term Care complies this order.

Grounds
1) The licensee has failed to ensure that the care set out in the responsive behaviour plan of care was provided to the resident as specified in the plan.

The behaviour plan of care documentation on point click care indicated that the resident required two staff to provide care. The video surveillance documentation revealed that the Personal Support Worker (PSW) entered the resident's room alone twice during the eight-hour shift night shift. No other staff entered the resident's room during that time, increasing the risk of injury to both the PSW and the resident.

Sources: Review of the licensee's video surveillance documents, resident care plan documents and interview with the Personal Support Worker (PSW) and the PSW Supervisor.

2) The licensee has failed to ensure that safety checks were completed every 15 minutes on one day for a resident as set out in the plan of care. This resulted in the resident exiting the building without staff knowledge of their whereabouts.

Sources: Resident health care records, and interview with a PSW and the Interim Assistant Deputy Administrator of Operations (IADAO).

3) The licensee has failed to ensure that the care set out in a resident's plan of care regarding repositioning was completed. On one shift, the resident did not get turned and repositioned every two hours resulting in skin breakdown.

Sources: Resident's health care documents, Critical Incident Report and an interview with the Interim DOC.

4) The licensee has failed to ensure safety checks were completed as per plan of care for a resident on two shifts. The resident was a fall risk and had a safety device in place. Staff reported the resident was frequently awake, would remove the safety device and would attempt to get up from bed without the assistance they required.

Sources: Point of Care documentation, hallway camera review notes, and an interview with a PSW.

5) The licensee has failed to ensure that the care set out in a resident's plan of care regarding repositioning the resident every two hours was provided. On a shift, this care was not provided as the resident was left unattended in their wheelchair with

the sling attached to the ceiling lift for four hours.

Sources: Resident's plan of care document, Critical Incident Report and an interview with the Operations Deputy Administrator.

This order must be complied with by December 6, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:

2022-11-03 NCA - 3577 Compliance Order FLTCA 2021 s. 6 (7)
2023-08-14 NCA - 20788 Compliance Order FLTCA s. 6 (7)

This is the second 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 #005 Policy to promote zero tolerance

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Review and revise the licensee's Prevention of Abuse and Neglect policy. The policy should be revised to contain all requirements identified in Ontario Regulation 246/22 s. 103.
B) Provide training to the Registered Nurse (RN) on the licensee's Prevention of

Abuse and Neglect policy, including the duty to immediately report allegations of abuse to the Director and the licensee's process for making these reports.
C) Keep a record of the training provided to the RN, including the date of the training, the training materials, and who delivered the training.
D) Provide training to all Managers and Supervisors on the licensee's Prevention of Abuse and Neglect policy, including the process for protecting residents from abuse and neglect once an allegation is made, the process of internal investigation and the process of disciplinary action. A record will be kept of the training provided to Managers and Supervisors including the date of the training and the training materials.

Grounds
1) The licensee has failed to ensure that the Prevention of Abuse and Neglect policy was complied with.

Specifically, The Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy stated that in cases where the allegation of abuse or neglect is made against an employee, the employee would be advised that they are being removed from the work schedule pending investigation. The policy further stated that staff who fail to report abuse or neglect in a timely manner would be subject to corrective action.

Two allegations of abuse were made by a resident's Substitute Decision Maker (SDM) for two shifts. A Personal Support Worker (PSW) and a Resident Care Assistant (RCA) cared for the resident on the first shift, and the PSW again cared for the resident again the following day. Staff schedules identified that the PSW and the RCA were never placed on a leave of absence pending investigation. The Interim DOC confirmed the staff were not placed on a leave of absence as they were not aware of this policy or practice. The Interim DOC further stated that the RCA was not

involved in the investigation and did not receive corrective action despite being present for the incident of alleged abuse during the first shift, and failing to report the incident. The Administrator stated this policy was put in place by the former Director of Care (DOC) and would have been in force at the time of this allegation.

Sources: Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, staffing schedules, Critical Incidents, interviews with the Interim DOC, the Administrator and other staff.

2) The licensee has failed to ensure that a Registered Nurse (RN) followed the licensee's zero tolerance of abuse and neglect policy.

Specifically, policy Zero Tolerance of Resident Abuse and Neglect Response and Reporting which stated that the registered nurse would call the manager on-call or designate immediately upon suspecting or becoming aware of abuse or neglect of a resident.

A Registered Nurse (RN) stated that they did not call the manager on-call or their designate when they became aware of an allegation of resident-to-resident abuse.

Failing to report incidents of resident to resident abuse immediately to the supervisor or manager on-call delays their investigation and mandatory reporting to the Director.

Sources: Review of the licensee's policy, Critical Incident System report (CIS) and interview of a RN and other staff.

3) The licensee has failed to comply with the home's written Zero Tolerance of Abuse and Neglect policy under section 25.

Specifically, the staff did not comply with the licensee's policy titled Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences. The licensee's Zero Tolerance of Abuse and Neglect policy required that in cases where the allegation of neglect is made against an employee, the employee will be placed on paid leave pending the investigation.

A Critical Incident system (CIS) report was submitted related to an allegation of neglect by a Personal Support Worker (PSW) to four residents. A review of the PSW's schedule showed that the PSW worked in the home while the internal investigation was being completed.

As such, by not placing the PSW on paid leave pending investigation, the residents were put at risk for ongoing neglect.

Sources: A review of licensee's policy tilted Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences; the home's investigation notes, the PSW's schedule and interview with the interim DOC.

4) The licensee has failed to comply with the home's written Abuse and Neglect policy under section 25.
Specifically, The home's policy titled Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences required management to immediately advise the employee that they were being removed from the work schedule, with pay, pending investigation.

An allegation of abuse of resident by a PSW was brought to the Interim DOC's attention and an investigation was conducted. The PSW continued to provide care to the resident during the investigation without immediately being placed on a leave

of absence with pay, pending investigation.

Sources: The home's policy tilted Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, Resident Document Survey report, the home's investigation notes. Interviews with the PSW and the Interim DOC.

5) The licensee has failed to ensure that the licensee's Zero Tolerance of Abuse and Neglect policy that was complied with.

Specifically, the licensee's Zero Tolerance of Abuse and Neglect policy titled; Zero Tolerance of Abuse and Neglect - Investigation and Consequences, which stated that in cases where an allegation of abuse or neglect is made against an employee, the employee will be placed on paid leave pending the investigation.

Critical Incident System report related to an allegation of Personal Support Worker (PSW) to resident neglect indicated that the PSW was not placed on paid leave pending the investigation.

By not following the licensee's policy to place the PSW on paid leave the pending investigation, residents were at risk for ongoing neglect.

Sources: Review of policy titled Zero Tolerance of Abuse and Neglect - Investigation and Consequences, Critical Incident System report, and interview of the Interim Director of Care (DOC) and the PSW Supervisor.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #006 Additional training — direct care staff

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (7)

Training

s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

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

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

The licensee shall:

1) Develop and complete an audit to identify all direct care staff including the two Personal Support Workers (PSWs) who have not completed the annual training according to FLTCA 2021, s. 82 (7).

2) Keep a written record of the audit performed.

3) Provide annual training according to FLTCA 2021, s. 82 (7) to all direct care staff identified in the audits including the two PSWs.

4) A record must be kept of the training provided that includes the training materials, the date of the training, who provided the training and all staff members who

attended.

Grounds
The licensee has failed to ensure that all staff who provide direct care to the residents received, as a condition of continuing to have contact with residents, annual training.

Review of Surge Learning completion status reports for the 2023 year, indicated that two Personal Support Workers (PSWs) did not receive any annual training. Furthermore, review of Surge Learning Course Completion records for the 2023 year, indicated the following:
- 38 out of 198 staff did not receive their annual training related to resident abuse and neglect.
- 28 out of 198 staff did not receive their annual training related to responsive behaviours.

Interview with a PSW and the Staff Development/Health and Safety Officer indicated that there were multiple staff who had not received their annual training in 2023.

Sources: Review of Surge Learning completion status reports and interview with the Staff Development/Health and Safety Officer, a PSW and other staff.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #007 Oral care

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

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

The licensee shall:
A) Perform an audit one time per week that reviews the care for the previous seven days and evenings for the two residents to ensure the residents are receiving oral care morning and evening for four weeks; and
B) Document the audits completed including the findings, and any corrective actions taken based on audit results.

Grounds
1) The licensee has failed to ensure that staff were providing mouth care morning and evening to a resident during a two-week period which resulted in reduced integrity of oral tissue. The resident required intervention to treat the oral issues identified.

Sources: Record reviews of resident electronic medical record, internal investigation file, and interviews with PSWs, a RN, a RPN, and the Interim DOC.

2) The licensee has failed to ensure that staff were providing mouth care morning and evening to a resident during a two-week period which resulted in reduced integrity of oral tissue. The resident required intervention to treat the oral issues

identified.

Sources: Record reviews of resident electronic medical record, internal investigation file, and interviews with a RN, a PSW, a RPN, and the Interim DOC.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #008 Transferring and positioning techniques

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:
A) The three identified residents and any other residents requiring a toileting sling for continence care are reassessed for safety while seated on the toilet without staff support.
B) Provide training to all direct care staff involved in the three identified residents care on the use of sling and mechanical lift as transferring and repositioning devices or techniques when assisting residents.
C) Conduct audits for a period of two weeks to ensure that the three residents and any other residents are not left hooked to the lift while toileting or seated/lying in bed or wheelchair.
D) Keep a written record of everything required under sections (A), (B) and (C), until

the Ministry of Long-Term Care complies this order.

Grounds

1) The licensee has failed to ensure that a PSW used safe transferring techniques when they transferred a resident from wheelchair to toilet without assistance of another staff. The resident's plan of care indicated that the resident required two staff members with a mechanical lift for all transfers.

Sources: Resident plan of care. Interview with a PSW.

2) The licensee has failed to ensure that a PSW used safe positioning techniques when assisting a resident with bed mobility. The resident's plan of care indicated that the resident required two staff members for repositioning every two hours. A PSW indicated that they assisted the resident with bed mobility without assistance of the second staff.

Sources: Resident plan of care, home's investigation notes and interview with a PSW.

3) The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident from their wheelchair to their bed using the ceiling lift.

Sources: Critical Incident Report and interviews with a RPN and the Operations Deputy Administrator.

This order must be complied with by December 6, 2024

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.