

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

Public Report

Report Issue Date: January 7, 2026

Inspection Number: 2025-1551-0006

Inspection Type:

Complaint
Critical Incident

Licensee: Corporation of the City of Cornwall

Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 15, 16, 18, 19, 22, 23, 30, 31, 2025 and January 5, 6, and 7, 2026

The inspection occurred offsite on the following date(s): December 24 and 29, 2025

The following intake(s) were inspected:

- Intake: #00160768 - related to a complaint with concerns regarding a resident's falls prevention and management.
- Intake: #00162010 - related to a complaint with concerns about a resident's medication and medical treatment device.
- Intake: #00161851 - related to a respiratory outbreak.
- Intake: #00162316- related to a resident's fall resulting in a significant change in the resident's condition.

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

Resident Care and Support Services

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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.

A resident was observed sleeping in their bed with the bed not in the lowest position. However, the intervention in the resident's plan of care was to ensure the bed was at the lowest position.

Sources: Resident's electronic health record, interviews with Personal Support Worker and Registered Practical Nurse.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

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

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).

1) The hand hygiene program did not include assisting residents to perform hand hygiene as multiple residents were not assisted by staff with their hand hygiene during a meal service on a specific day.

Sources: Inspector's observations of a lunch meal service and interview with Personal Support Worker.

2) A Personal Support Worker (PSW) did not perform hand hygiene after removing a used mask and prior to putting on a new mask. Additionally, a Registered Practical Nurse (RPN) and two PSWs did not wear the required eye protection prior to entering rooms that were on droplet precautions.

Sources: Inspector's observations of RPN and PSWs, interviews with PSWs and Staff Development Health and Safety Officer.