

**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:** April 1, 2026

**Inspection Number:** 2026-1551-0001

**Inspection Type:**  
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): March 25- 27, March 30-31, 2026 and April 1, 2026

The following intakes were completed in this Critical Incident (CI) inspection  
Intake#00165688/CI #M529-000093-25 and Intake #00173025/CI-M529-000014-26 were related to falls prevention and management

Intake #00168913/CIM529-000003-26, Intake: #00172026 /CI# M529-000008-26, and Intake #00172084/CI #M529-000009-26 were related to allegations of resident to resident physical abuse.

Intake #00169833/CI #M529-000005-26 was related to an allegation of resident to resident verbal abuse

Intake #00173739/CI # M529-000018-26 was related to an allegations of improper/Incompetent treatment

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

Responsive Behaviours  
Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Falls Prevention and Management

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

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

A specific resident was identified as being at a high risk for falls with a specific falls prevention interventions required to mitigate this risk. During an observation on a specified date, the required falls prevention interventions was not in place for the resident. During an interview, a Personal Support Worker (PSW) confirmed that the intervention should have been in place for the resident at the time of the observation.

Sources: The resident's medical records, an observation and an interview with a PSW.

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## **WRITTEN NOTIFICATION: Falls Prevention and Management**

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

**Non-compliance with: O. Reg. 246/22, s. 54 (2)**

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The home's Falls Prevention and Management Program required Direct Care Staff to not move a resident found on the floor, to not leave the resident unattended and to call for registered staff assistance. On a specified date, a Personal Support Worker (PSW) found a specific resident on the floor. However, the PSW did not follow the home's Falls Prevention and Management program as required.

Sources: Resident 's medical records, Falls Prevention and Management Program RC-15-01-01 last updated March 2026, specific Critical Incident Report (CIR), and interviews with the PSW and a Director of Care (DOC).

## **WRITTEN NOTIFICATION: Behaviours and altercations**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 60 (a)**

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,  
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

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On a specified date a resident demonstrated a responsive behaviour towards another resident, resulting in the second resident sustaining an injury.

During an interview, the Director of Care (DOC) stated that a specific interventions had been implemented to manage the resident's responsive behaviours as of a specific date.

However, during interviews with two Personal Support Workers (PSW), they indicated that they were aware the resident required the implementation of the specific intervention, and confirmed that the intervention was not in place at the time of the incident.

Sources: Interviews with DOC, three PSWs, a Registered Practical Nurse, a review of the resident with responsive behaviour's, clinical records.