

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: November 6, 2025

Inspection Number: 2025-1601-0003

Inspection Type:

Critical Incident

Licensee: Corporation of the County of Grey

Long Term Care Home and City: Grey Gables Home for the Aged, Markdale

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 27-30, 2025 and November 3-6, 2025

The following intake(s) were inspected:

- Intake #00157645 was related to infection prevention and control;
- Intake #00157941 was related to allegations of abuse;
- Intake #00158768 and intake #00160151 were related to responsive behaviours.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

WRITTEN NOTIFICATION: Duty to Protect

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

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 licensee failed to ensure that the long-term care home protected the resident from abuse by anyone.

A resident sustained injuries from an unwitnessed physical altercation with a co-resident.

Sources: Resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

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 licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

A resident alleged that a Personal Support Worker (PSW) hit them. A different PSW reported the allegation to the nurse. Although the home's investigation did not substantiate the abuse allegation, the home failed to follow their abuse and neglect policy, did not interview or follow up with relevant parties involved, did not report immediately as per their policy, and the PSW continued working.

Source: Clinical records, the home's prevention of abuse and neglect policy, and interviews with staff.

WRITTEN NOTIFICATION: Reporting to the Director

NC #003 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 failed to immediately report allegations of abuse by a resident that resulted in harm to a co-resident to the Director.

A resident sustained injuries after an unwitnessed altercation with another resident. The incident was not reported to the Director immediately, and a critical incident report was not submitted until the following day.

Sources: The home's investigation file, and interview with staff.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee failed to ensure that the written strategies were implemented to prevent or minimize or respond to the responsive behaviours.

A resident was involved in an altercation with a co-resident. The resident's psychotropic medications had been reduced prior to this incident. There were multiple days that the resident had aggressive behaviours after the altercation. There was a second incident noted with a different co-resident that resulted in injuries to the resident.

Sources: Clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #005 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

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that steps are taken to minimize the risk of altercation and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A resident was found in a co- resident's room when a PSW completed their resident checks. The resident sustained injuries as a result of an unwitnessed altercation. The co-resident had a door sensor in place to alert staff if a resident wandered into their room. However, the door sensor did not alarm when the resident entered the room, as it was not turned on as per the care plan.

Sources: Clinical records, email from on call ADOC, and interview with DOC.

WRITTEN NOTIFICATION: Police Notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriated police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

A) A resident sustained injuries following an unwitnessed altercation with a co-resident. When the RPN found the residents, the co-resident was standing near the resident and had their hand in a fist. The DOC confirmed that the police had not been notified of the incident.

Sources: Clinical records, and interview with DOC.

B) A resident sustained injuries following an unwitnessed altercation with a co-resident. The PSW found the resident was in a co-resident's room. The DOC confirmed that the police had not been notified of the incident.

Sources: Clinical records, and interview with DOC.