

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: February 26, 2026
Inspection Number: 2026-1601-0001
Inspection Type: Complaint Critical Incident Follow up
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): February 11-13, 17, 19, 20, 23-25, 2026.

The inspection occurred offsite on the following date(s): February 18, 2026.

The following intake(s) were inspected:

-Intake: #00165649 - Follow-up #: 1 - O. Reg. 246/22 - s. 140 (2), Medication Management

-Intake: #00166042: related to a disease outbreak

-Intake: #00163512, Intake: #00165368, Intake: #00165819, Intake: #00166247,

Intake: #00168223: related to allegation of resident abuse.

-Intake: #00166702: related to medication management

-Intake: #00166901: Complaint related to an allegation of resident abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1601-0004 related to O. Reg. 246/22, s. 140 (2)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

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.

According to O. Reg 246/22 s. 2 (1)(c), for the purposes of the Act and this Regulation, the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)

A resident was struck by another resident on more than one occasion causing injury. The home did not take action to protect the resident from harm by implementing additional interventions to prevent further altercations.

Sources: Review of progress notes, police report and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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.

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In accordance with FLTCA s.154 (3), the licensee is vicariously liable when a staff member has not complied with subsection 28 (1) of the FLTCA.

An allegation of improper treatment of a resident was witnessed by a staff member. The staff member did not report the incident immediately to the Ministry of Long-Term Care.

Sources: Critical Incident, resident progress notes, staff written statement, interview with the Resident Care Coordinator.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.

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:

3. Resident monitoring and internal reporting protocols.

The Dementia Observation System (DOS) documentation for a resident was not completed on multiple occasions. The home identified that the incomplete and delayed assessment and observations created a missed opportunity to form a comprehensive or accurate assessment of a resident's behaviour.

Source: Resident's clinical records and interview with staff.

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 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A) While providing care to a resident, staff failed to implement strategies to manage the resident's responsive behaviours.

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Sources: resident's plan of care, interview with the DOC.

B) A resident had a history of responsive behaviours. Strategies were not developed or implemented to assist staff with managing the responsive behaviours.

Sources: review of progress notes, plan of care for a resident, and interviews with PSW and the Director of Care.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #005 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

Procedures and interventions were not developed and implemented to assist a resident who was at risk of harm from a co-resident after repeated negative altercations that resulted in an injury.

Source: a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A Registered Practical Nurse (RPN) administered medications that were not prescribed for a resident. As a result the resident became ill shortly after receiving the incorrect

medications.

Sources: Interviews with the DOC and RPN, a resident's progress notes, Medication incident report, Investigation interview.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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