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

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Public Report

Report Issue Date: May 23, 2025
Inspection Number: 2025-1419-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: St. Joseph's at Fleming
Long Term Care Home and City: St. Joseph's at Fleming, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-2, 5-9, 12-16, 20-22, 2025.

The following intake(s) were inspected:

- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of staff to resident neglect.
- An intake regarding an allegation of staff to resident neglect.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of neglect for a resident.
- An intake regarding an allegation of improper care of a resident
- An intake regarding a medication incident.
- An intake regarding an allegation of resident-to-resident abuse.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an unexpected death of a resident.
- An intake regarding an injury of unknown origin for a resident.
- An intake regarding a missing resident.
- An intake regarding an allegation of staff to resident abuse.

- An intake regarding a missing resident.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of improper use of a restraint.
- An intake regarding an allegation of neglect of a resident.
- An intake regarding an allegation of staff to resident abuse.
- An intake regarding an injury of unknown origin.
- An intake regarding an allegation of improper care of a resident
- An intake regarding an allegation of staff to resident abuse.
- An intake regarding an allegation of neglect for a resident.
- An intake regarding a complaint with allegations of resident neglect.
- Follow-up #1, CO #004, FLTCA, 2021, s. 25 (1) Policy to Promote Zero Tolerance of Abuse in #2024-1419-0003, with a CDD for March 31, 2025.
- Follow-up #1, CO #002, FLTCA, 2021, s. 6 (7) Plan of Care in #2024-1419-0003, with a CDD for March 3, 2025.
- Follow-up #1, CO #001, O. Reg. 246/22, s. 147 (1) Medication incidents and adverse drug reactions, in #2024-1419-0003, with a CDD for March 31, 2025.
- Follow-up #1, CO #003, FLTCA, 2021, s. 7 Consent, in #2024-1419-0003, with a CDD of March 3, 2025.
- An intake regarding an unexpected death of a resident.
- A complaint regarding concerns of a staff member.
- An intake regarding an allegation of neglect of a resident.
- An intake regarding an unexpected death of a resident.
- An intake regarding an allegation of resident-to-resident abuse.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of neglect of a resident.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of improper care of a resident.
- Two Intakes regarding an allegation of neglect of a resident.
- An intake regarding an allegation of neglect of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1419-0003 related to FLTCA, 2021, s. 6 (7)
Order #001 from Inspection #2024-1419-0003 related to O. Reg. 246/22, s. 147 (1)
Order #003 from Inspection #2024-1419-0003 related to FLTCA, 2021, s. 7

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #004 from Inspection #2024-1419-0003 related to FLTCA, 2021, s. 25 (1)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Palliative Care
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's choices were respected when a Personal Support Worker (PSW) changed the resident into their pajama top when the resident indicated it was too early and wanted to wait.

Sources: A resident's clinical health records, a Critical Incident Report (CIR), and internal investigation records.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident was given the opportunity to participate in the implementation of the resident's plan of care. A resident had a fall and was complaining of pain. The resident requested the registered staff transfer them to hospital however they were not sent until later that day. A Home Area Manager (HAM) confirmed the resident was their own Substitute Decision Maker (SDM), and the registered staff should have transferred the resident to hospital when they requested.

Sources: A **CIR, a resident's clinical records, investigation notes, and an interview with a HAM.**

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 has failed to ensure a resident was protected from neglect by a PSW.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident was resisting care and sustained an injury when a PSW continued to provide the resident's personal care. The HAM confirmed that when the resident was actively resisting care the PSW should have stopped providing care to the resident. The HAM further confirmed as a result of the PSW not stopping care the resident sustained a injury.

Sources: Policy- Abuse and Neglect-Zero Tolerance, a resident's clinical records, internal investigation records, and an interview with a HAM.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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.

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect was complied with. The assessments of three residents were not immediately completed following the allegations of improper care. The Ministry of Long-Term Care, (MLTC) and the police were not immediately notified of the allegations, as per the home's abuse policy.

Sources: Three CIRs, internal investigation records, Abuse and Neglect (Resident) - Zero Tolerance Policy.

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect was complied with by a Registered Practical Nurse (RPN). The home’s Abuse and Neglect-Zero Tolerance policy indicated it was the responsibility of the employee who witnessed or suspected alleged abuse or neglect to immediately report any witnessed, suspected or alleged abuse to the Charge Nurse/Delegate. A resident's family member reported the resident was not provided continence care when they rang their call bell. A Registered Nurse (RN) indicated the RPN did not report to them the allegation of neglect until the following day. The HAM confirmed that the RPN did not report the allegation of neglect to the RN until the following day at which time the MLTC action line was called.

Sources: A CIR, Policy to promote zero tolerance, clinical records, internal investigation records, and an interview with a HAM.

3. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when a resident’s

continence care was delayed, on two separate occasions. The Director of Resident Care (DRC), and a HAM confirmed there was no documentation of the investigation forms completed, or interviews from the accused staff and witnesses following the allegations of neglect. The RN and HAM recalled completing the resident's head-to-toe skin assessment following the allegations of neglect. There was no documentation provided to verify that the registered staff had completed as assessment of the resident.

Sources: Two CIRs, a resident's clinical health records , Abuse and Neglect (Resident) - Zero Tolerance Policy and staff interviews.

4. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with when a resident's SDM reported to the RN that staff were not applying the resident's sling properly. The HAM confirmed there was no documentation of the investigation forms completed, or interviews from the accused staff and witnesses following the allegations of improper care.

Sources: A CIR, a resident's clinical health records, Abuse and Neglect (Resident) - Zero Tolerance Policy, and an interview with a HAM.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements

that may be provided for in the regulations.

1. The licensee has failed to forward a complaint to the Director regarding alleged harm to a resident.

A resident's SDM emailed a written complaint to the licensee expressing concerns about neglect and care. HAM #148 received the email and did not forward the written complaint to the Director.

Sources: A CIR, and interview with the DRC.

2. The licensee has failed to forward a complaint to the Director regarding a resident.

A resident's SDM emailed a written complaint to the licensee expressing concerns about care and communication. HAM #105 received this email and did not forward the written complaint to the Director.

Sources: A CIR, internal investigation records and an interview with the DRC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

The licensee has failed to ensure that an allegation of neglect for a resident was immediately investigated. An RPN indicated that they did not participate in any follow up regarding the incident and the RPN was not aware of any investigation into the allegation. The CIR did not include any long term actions and the outcome of the internal investigation. There was no documentation to support that HAM #148 had communicated with the involved staff. The DRC indicated that no modifications were made to the resident's care plan to prevent similar occurrences. The DRC confirmed that the home's investigation process was not followed.

Sources: A resident's clinical records, a CIR, internal investigation records, and staff interviews.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (iii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(iii) anything else provided for in the regulations;

The licensee has failed to ensure that when a resident was found to have an injury of unknown cause, an investigation was completed. The resident was sent to the hospital for an assessment and an investigation was not completed.

Sources: A resident's clinical records, a CIR, and an interview with the DRC.

WRITTEN NOTIFICATION: Licensee must investigate, respond

and act

NC #008 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 take appropriate action in response to an allegation of neglect.

A CIR was submitted to the Director concerning an allegation of neglect involving a resident. The CIR indicated that a head-to-toe assessment, and an assessment for any signs of psychological or emotional distress, would be conducted immediately in response to the allegation. However, during a review of the resident's clinical record there was no indication of a head-to-toe assessment being completed. Furthermore, while the clinical records noted that the resident would be assessed for psychological and emotional distress using a Dementia Observation System (DOS) tool, the review of the DOS documentation showed that the evaluation was incomplete.

Sources: A CIR, a resident's clinical records, and an interview with the DRC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #009 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.

The licensee has failed to ensure that the Director was immediately informed when a PSW reported allegations of improper continence care to the RN. The RN acknowledged the resident had been incontinent and required immediate continence care and the Director was not notified. A CIR was submitted to the Director regarding the allegations of improper care, a few days after the incident occurred.

Sources: A CIR, and an interview with the RN.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #010 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 has failed to ensure that an allegation of sexual abuse between two residents was immediately reported to the Director.

Sources: A CIR and an interview with the DRC.

WRITTEN NOTIFICATION: Police record checks

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 81 (2)
Screening measures
s. 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

The licensee has failed to ensure a police record check was conducted when a PSW was hired.

Sources: A PSW's employee file.

WRITTEN NOTIFICATION: Licensee must comply

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #004 from Inspection #2024_1419_0003 served on December 9, 2024, with a compliance due date of March 31, 2025.

The required corrective action was not taken by the DRC or designate according to the Zero Tolerance for Abuse and Neglect policy when deficiencies occurred.

The auditing for the Zero Tolerance for Abuse and Neglect policy as per the order was completed for six weeks. HAM #105 confirmed that during the auditing period the corrective action as outlined in the compliance order for points three and four were incomplete.

Sources: CO #004 from #2024_1419_0003, audits, and an interview with HAM #105.

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #012

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:
No History.

This is the first 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.

WRITTEN NOTIFICATION: Required programs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's falls prevention and management program. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's Falls Prevention and Management Program was not followed when a resident fell. The policy indicated that when a resident fell the PSW was to notify the registered staff to assess the resident prior to moving the resident, the registered staff was to assess and document a post falls assessment, head injury routine, risk management and a head-to-toe assessment. The HAM confirmed PSW'#103 and PSW #139 did not notify the registered staff to assess the resident prior to moving. The HAM further confirmed post resident fall the registered staff did not complete the head-to-toe assessment, head injury routine assessment, post falls assessments, and risk management, as result the registered staff and PSWs did not comply with the Falls Prevention and Management Program.

Sources: A CIR, Falls Prevention and Management Program policy, a resident's clinical records, and an interview with a HAM.

WRITTEN NOTIFICATION: Required programs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that a resident's pain was managed and that the pain policy was complied with when the resident had pain due to an injury.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a pain management program to identify pain in residents and manage pain and it must be complied with.

Specifically, staff did not comply with the licensee's pain management program when the registered nursing staff did not complete a Pain Assessment Decision Tree, as directed in the policy. The resident had a change in health status and their pain was not relieved by the initial interventions and alternative approaches to manage the resident's pain was not documented. The resident's pain was being assessed using the Pain Assessment in Advanced Dementia (PAINAD), Numerical score and the comprehensive pain assessment. The resident's pain score was 5 or greater on either the numerical or PAINAD scale on several occasions. The resident required as needed pain medication for greater than 72 hours and the physician or nurse practitioner were not informed when the resident's pain was not well-controlled. The resident's care plan was not based on the resident's assessed condition and the location, type and patterns of pain episodes, and contributing factors.

Sources: Pain Management Policy, a resident's clinical health records, and an interview with a HAM.

WRITTEN NOTIFICATION: Skin and wound care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident was reassessed at least weekly by registered nursing staff when the resident sustained a bruise. The HAM #107 acknowledged that weekly assessments should have been completed.

Sources: Policy- Skin and Wound Care Program, a resident's clinical records, and an interview with a HAM.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

1. The licensee has failed to ensure that a resident who was incontinent, was provided sufficient changes to their continence product to remain clean, dry and

comfortable when the resident was found with urine saturated clothing and bed linen.

Sources: A CIR, internal investigation records and and an interview with a HAM.

2. The licensee has failed to ensure that a resident received continence care to remain clean, dry and comfortable. Investigation notes and progress notes indicated that the resident was incontinent of stool during the night. PSW #134 and PSW student #140 indicated that the resident had dry stool on their fingers and skin. The HAM confirmed adequate continence care was not provided during the night when the resident was observed with dry stool on their skin and fingers in the morning.

Sources: A resident's clinical records, internal investigation records, and an interview with a HAM.

3. The licensee has failed to ensure that a resident who was incontinent, was provided sufficient changes to their continence product to remain clean, dry and comfortable on two occasions, when the resident was found with a saturated clothing and brief.

Sources: Two CIRs.

4. The licensee has failed to ensure a resident had sufficient changes to remain clean, dry and comfortable. The resident's incontinence brief, bedding and clothing were found saturated in urine.

Sources: POC documentation, and a CIR.

WRITTEN NOTIFICATION: Responsive behaviours

NC #017 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

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident responsive behaviours when they refused care.

The investigation notes indicated that the resident refused to change their soiled clothing at bedtime. A PSW was able to provide continence care during the night however was unable to change the residents soiled clothing. Record review over a four-week period indicated the resident continued to be resistive to care, refused medications, and refused to be transferred to the dining room. HAM #105 confirmed there were no strategies, developed and implemented to respond to the resident's responsive behaviour when they refused care.

Sources: A **CIR, internal investigation records, a resident's clinical records, and interview with HAM #105.**

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #018 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 among residents, including,

(b) identifying and implementing interventions.

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

A CIR was submitted regarding an incident of resident-to-resident abuse. A review of a resident’s clinical monitoring records following the incident indicated that risk-related behaviours continued to occur on a daily basis. However, an examination of a resident’s care plan revealed that no new interventions or modifications had been implemented since before the incident.

Further review of the resident’s clinical documentation and the home’s internal investigation file confirmed the absence of any newly introduced interventions. The HAM acknowledged that a review of the Behaviour Support Observation (BSO) notes showed no new strategies had been put in place for the resident. The HAM also confirmed, upon review of the progress notes, that the resident continued to exhibit risk behaviours, including further negative interactions with both staff and co-residents.

Sources: A resident's clinical health records, internal investigation records and an interview with a HAM.

WRITTEN NOTIFICATION: Palliative care

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident’s palliative care needs for their plan of care considers the resident’s physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee has failed to ensure that a resident received an assessment by the interdisciplinary team, including the physician to meet the resident's palliative care needs. The resident had a decline in physical condition and their plan of care was not updated to consider the resident's physical, emotional, and spiritual needs. The HAM confirmed the plan of care should have been updated so that staff were aware of the interventions to meet the resident's physical and emotional needs for comfort.

Sources: Internal investigation records, palliative care checklist, the resident's clinical records, and an interview with a HAM.

WRITTEN NOTIFICATION: Dealing with complaints

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the written complaint included the Ministry's toll-free telephone number for lodging complaints about homes, its hours of operation, and the contact information for the Patient Ombudsman, as required by legislation.

A written complaint was submitted to the home requesting follow-up information on how to contact the Ministry. The DRC confirmed that the home's standard procedure was to include both the Ministry and Ombudsman contact details in such communications. However, this protocol was not followed in this instance. The licensee's response both at the time of the initial email and upon conclusion of the complaint follow up, did not include the information requested by the complainant, nor did it meet the legislative requirements.

Sources: A CIR, internal investigation records and interview with the DRC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee has failed to ensure that the CIR submitted to the Director was amended at the conclusion of the home's investigation to include the analysis and follow-up action, including, the immediate actions and the long-term actions that were taken to prevent recurrence of neglect for a resident.

Sources: A CIR, and and an interview with the DRC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
3. A resident who is missing for three hours or more.

The licensee has failed to ensure the Director was immediately informed in as much detail as possible when a resident was missing for more then three hours on two separate occasions.

Sources: A **CIR, a resident's clinical records.**

WRITTEN NOTIFICATION: Reports re critical incidents

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

1. The licensee has failed to inform the Director of the name of the staff involved in the CIR.

The home submitted a CIR about an incident of neglect. The home did not include the staff names involved in the incident and did not complete any amendment to the report at the conclusion of the home's investigation.

Sources: A CIR.

2. The licensee has failed to ensure that the names of the individuals who were involved in the incident were included in the CIR to the Director.

Sources: A CIR.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee has failed to ensure that a CIR submitted to the Director included the required outcome of the incident. A request for additional information was sent on the same date, but the CIR was not updated until several days later and did not include the requested information.

Sources: A CIR and internal investigation record.

WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 7.
Prohibited devices that limit movement
s. 121. For the purposes of section 38 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

The licensee has failed to ensure that a prohibited device was not used on a resident. The internal investigation determined that PSW #128 and PSW #129 had used an alternative method to restrict the movement of the resident's hands instead of following the intervention in the resident's plan of care.

Sources: A CIR, internal investigation records, and a progress note.

WRITTEN NOTIFICATION: Medication management system

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the home’s medication management system. In accordance with O. Reg 246/22, s 11(1) (b), the licensee was required to ensure that written policies developed for medication management system were complied with. Specifically, the home's policy regarding a medication indicated that for safety reasons, resident specific type of medication should be stored separately from each other. Observation of a resident's medication drawer identified that the two specified medications were stored together in the same medication drawer. A HAM and RN confirmed that when a resident had more then one type of medication ordered they were stored in the same resident medication bin and were not stored separately.

Sources: Policy-Handling of Medications, observation, and interview with an RN, and a HAM.

WRITTEN NOTIFICATION: Administration of drugs

NC #027 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).

The licensee has failed to ensure that the correct medication was administered to a resident in accordance to the direction, as specified by the prescriber. The resident's e-MAR and order summary report indicated that the registered staff were to administer a medication at bedtime. The RN confirmed they administered a different medication at bedtime and did not follow the directions in the resident's e-MAR.

Sources: A CIR, a resident's clinical records, and an interview with an RN.

COMPLIANCE ORDER CO #001 Plan of care

NC #028 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:

1. The HAM or designated registered staff is to conduct daily audits by speaking with resident #032 for a period of two weeks to ensure the resident has received continence care, as specified in the plan.

2. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and provide the audits to the Inspector.

3. Review the care plans for residents #029 and #012 to determine interventions for registered staff when assigning PSWs, ensuring female staff are allocated when available. If female staff are unavailable, determine alternative staff interventions.

4. The DRC or designate will review and communicate interventions with resident #012, #029, and their SDM for input. After discussion, update the care plan and communicate with staff the changes. Keep a documented record of the updated plan of care, the content of the communication with the resident, SDM and staff, and the date of the communication.

5. Review resident #027's behavioural care plan interventions to ensure the resident's assessed needs are met. Maintain a written record of the care plan

review for resident #027 including the date of review and who participated.

6. Provide education to PSW #144 on resident #027's revised behavioural interventions. Provide a written record of the education.

Grounds

1. The licensee has failed to ensure that the care set out in resident #032's plan of care was provided when the PSWs did not provide the resident's scheduled continence care during the night shifts on three occasions. The resident reported the allegations of not receiving their continence care on the three occasions. The resident's plan of care indicated they required two staff to provide continence care during the night at 0100 hour and 0400 hour. The HAM confirmed that the internal investigations determined that the resident had not received their continence care, as specified in the resident's plan of care.

The resident was at risk for experiencing discomfort, impaired dignity and altered skin integrity when the resident did not receive adequate continence care.

Sources: Internal investigation records, a resident's clinical records, and an interview with a HAM.

2. The licensee has failed to ensure that mouth care was provided to a resident at bedtime when their dentures were not cleaned or removed by a PSW.

The next day the resident was experiencing mouth pain and had signs and symptoms of an infection.

Sources: A resident's clinical health records, a CIR and the internal investigation records.

3. The licensee has failed to ensure that a resident's blood pressure and heart rate was taken on bilateral arms as ordered by the physician.

The resident was at risk for improper monitoring of their health condition when the prescriber orders were not followed.

Sources: A resident's clinical health records, a CIR and an interview with a HAM.

4. The licensee has failed to ensure that the care set out in a resident’s plan of care was provided when the PSW attempted to provide the resident’s continence care in bed without a second staff member present. The resident’s plan of care indicated they required two staff to provide care for pain management and bed mobility.

The resident had pain and was at risk for experiencing discomfort and altered skin integrity when the resident did not receive adequate continence care.

Sources: Internal investigation records, plan of care, and an interview with a HAM.

5. The licensee has failed to ensure that the care set out in the plan of care for resident #012 was provided to the resident as specified in the plan. The resident’s care plan was updated after they reported an allegation of sexual abuse towards them by a male PSW. The care plan indicated no male caregivers when possible. In December 2024, male PSW's provided personal care to the resident, despite female PSWs working on the same unit on three occasions. A HAM confirmed that the male PSW should have switched with female staff to comply with the care plan.

There was an increased risk of the resident responsive behaviors with further allegations of sexual abuse by the resident towards male staff when they continued to provide personal care to the resident.

Sources: A CIR, a resident's clinical records, home's staff schedules, and an interview with a HAM.

6. The licensee has failed to ensure that the care set out in resident #027's plan of care was provided, as specified. PSW #144 did not use the stop and go approach when the resident exhibited physically responsive behaviours and resisted care.

There was a risk of emotional distress and potential physical harm due to unmanaged responsive behaviours.

Sources: A resident's clinical health records, internal investigation records, and interviews with staff.

7. The licensee has failed ensure that the care set out in the plan of care was provided to resident #029, as specified in the plan. The resident's care plan indicated the resident requested no male staff for personal care. The resident asked a male PSW if a female PSW was available for continence care. The male PSW reported the female PSW was busy, and the resident agreed to proceed. A HAM confirmed that the male PSW should have arranged for a female PSW to provide the resident continence care to ensure the care plan was followed.

The resident's emotional health may be impacted as they requested female staff to provide them personal care, when the male PSW reported they were busy the PSW was not respecting the residents request as outlined in their plan of care.

Sources: A resident's clinical health records, internal investigation records, and an interview with a HAM.

This order must be complied with by August 1, 2025

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

Prior non-compliance with FLTCA, 2021, s. 6 (7) included:
- CO, AMP for $4,400 in inspection #2025-1419-0001 issued on March 10, 2025.
- CO, AMP for $3,300 in inspection #2024-1419-0003 issued on December 9, 2024.
- CO, AMP for $2,200 in inspection #2024-1419-0002issued on October 21, 2024.
- CO(HP), AMP $1,100 in inspection #2024-1419-0001 issued on April 15, 2024.
- WN in inspection #2023-1419-0003 issued on November 24, 2023.
- CO(HP) in inspection #2022-1419-0001 issued on November 3, 2022.

This is the fifth+ 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 #002 Responsive behaviours

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

1. The DRC or designate will develop and implement a process to ensure the DOS assessments are completed by staff. Communicate with staff the developed process. Keep a documented record of the process developed and implemented and the content of the communication to staff.

2. For four weeks, when the BSO analyzes the DOS and if there are incomplete

entries the BSO team will provide the incomplete DOS to the DRC or designate. The DRC or designate will provide corrective action to those staff who missed DOS entries. Keep a documented record of the incomplete resident's DOS, the manager that provided the corrective action, the staffs name that the education was provided to, and the content of the education.

Grounds

1. The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessments. A PSW provided the resident's morning care while the resident was being resistive to the care, as a result the resident sustained an injury. A DOS assessment was implemented for five-days to monitor the residents emotional and responsive behaviours after the incident. A HAM confirmed the DOS was incomplete during the five-day observation period.

There was an increased risk when the DOS was incomplete with key observations, as potential interventions may have been missed to support the resident.

Sources: Responsive Behaviour Program Prevention and Management, the resident's DOS, and an interview with a HAM.

2. The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessments. the resident had a behavioural altercation with a co-resident. A DOS assessment was implemented for five-days. The DOS was incomplete during the five-day observation period. A HAM confirmed the DOS was not complete and reported the DOS was implemented to monitor the resident's responsive behaviour and to monitor their emotional behaviour after the incident.

There was an increased risk when the DOS was incomplete with key observations, as potential interventions may have been missed to support the resident.

Sources: Responsive Behaviour Program Prevention and Management, a resident's DOS, and an interview with a HAM.

3. The licensee has failed to ensure that actions were taken to respond to the needs of a resident, including assessments. The resident had a behavioural altercation with a co-resident. A DOS assessment was implemented for five-days. The DOS was incomplete during the five-day observation period. A HAM confirmed the DOS was not completed and reported the DOS was implemented to monitor the resident's responsive behaviour after the incident.

There was an increased risk when the DOS was incomplete with key observations, as potential interventions may have been missed to support the resident.

Sources: Responsive Behaviour Program Prevention and Management, a resident's DOS, and an interview with a HAM.

4. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments. The resident reported an allegation of sexual abuse towards them by a male PSW. A DOS was started to assess the resident's emotional status. The DOS was incomplete and there was no documented DOS assessments of the residents behaviour during the night after the incident was reported.

There was an increased risk when the DOS was incomplete with key observations, as potential interventions may have been missed to support the resident.

Sources: Responsive Behaviour Program Prevention and Management, the residents clinical health records, internal investigation records, and an interview with the DRC.

5. The licensee has failed to ensure that appropriate actions, including

assessments, were taken for residents with responsive behaviours. In the morning, a resident was upset due to incontinence and alleged that night staff did not provide continence care. A three day DOS was initiated to assess the resident's emotional state and behaviours. A HAM confirmed the DOS assessment was incomplete.

There was an increased risk when the DOS was incomplete with key observations, as potential interventions may have been missed to support the resident.

Sources: Responsive Behaviour Program Prevention and Management, a resident's clinical health records, DOS assessment, and an interview with a HAM.

This order must be complied with by August 1, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.