Ontario

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

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

Public Report

Report Issue Date: August 1, 2025

Inspection Number: 2025-1419-0003

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): July 8 – 11, 14 - 18, 22 - 25, 2025.
The inspection occurred offsite on the following date(s): July 21, 28 - 30, 2025.

The following intake(s) were inspected:
- An intake regarding allegations of improper care of residents.
- 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 neglect of a resident.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding a resident-to-resident altercation.
- An intake regarding an allegation of incompetent care of a resident.
- An intake regarding an allegation of improper care of a resident.
- An intake regarding an allegation of improper transfer of a resident.
- Follow-up #1, CO #013 from inspection 2025-1419-0001, O. Reg. 246/22, s. 108 (3) regarding dealing with complaints with a CDD of May 2, 2025.
- Follow-up #1, CO #014 from inspection 2025-1419-0001, O. Reg. 246/22, s. 140 (3) (b) (ii) related to administration of drugs with a CDD of May 30, 2025.
- Follow-up #1, High Priority CO #002, AMP #001 for $22000.00 from inspection 2025-1419-0001, FLTCA, 2021, s. 24 (1) related to duty to protect with a CDD of May 2, 2025.
- Follow-up #1, CO #005, AMP #003 for $4400.00 from inspection 2025-1419-0001, FLTCA, 2021, s. 6 (7) related to plan of care with a CDD of May 2, 2025.
- Follow-up #1, High Priority CO #001 from inspection 2025-1419-0001, FLTCA, 2021, s. 6 (4) (a) related to plan of care with a CDD of May 2, 2025.

- Follow-up #1, CO #006 from inspection 2025-1419-0001, FLTCA, 2021, s. 6 (9) 1 related to plan of care with a CDD of May 30, 2025.
- Follow-up #1, CO #004 from inspection 2025-1419-0001, FLTCA, 2021, s. 6 (5) related to plan of care with a CDD of May 2, 2025.
- Follow-up #1, CO #010 from inspection 2025-1419-0001, O. Reg. 246/22, s. 55 (2) (b) (iv) related to skin and wound care with a CDD of May 30, 2025.
- Follow-up #1, CO #007, AMP #004 for $2200.00 from inspection 2025-1419-0001, O. Reg. 246/22, s. 40 related to transferring and positioning techniques with a CDD of May 2, 2025.
- Follow-up #1, CO #012, AMP #007 for $5500.00 from inspection 2025-1419-0001, O. Reg. 246/22, s. 56 (2) (g) related to continence care and bowel management with a CDD of May 2, 2025.
- Follow-up #1, CO #008, AMP #005 for $5500.00 from inspection 2025-1419-0001, O. Reg. 246/22, s. 53 (1) 1 related to required programs with a CDD of May 2, 2025.
- Follow-up #1, CO #011 from inspection 2025-1419-0001, O. Reg. 246/22, s. 55 (2) (e) related to skin and wound care with a CDD of May 30, 2025.
- Follow-up #1, High Priority CO #003, AMP #002 for $11000.00 from inspection 2025-1419-0001, O. Reg. 246/22, s. 140 (2) related to administration of drugs with a CDD of May 30, 2025.
- Follow-up #1, CO #015 from inspection 2025-1419-0001, O. Reg. 246/22, s. 260 (1) related to retraining with a CDD of May 30, 2025.
- Follow-up #1, CO #009, AMP #006 for $5500.00 from inspection 2025-1419-0001, O. Reg. 246/22, s. 55 (2) (b) (i) related to skin and wound care with a CDD of May 30, 2025.
- An intake regarding an allegation of neglect of residents.
- A complaint related to medication management for a resident.
- An intake regarding a resident-to-resident altercation.
- An intake regarding a resident-to-resident altercation.
- An intake regarding a complaint related to the operation of the home.
- An intake regarding an allegation of improper care of residents.
- A complaint related to an allegation of abuse and retaliation.
- An intake regarding a complaint related to resident care.
- An intake regarding an allegation of verbal abuse by staff.
- An intake regarding allegations of staff to resident abuse.
- Follow-up #2, CO #004 from inspection 2024-1419-0003, FLTCA, 2021, s. 25 (1), related to Policy to Promote Zero Tolerance of Abuse with a CDD of March 31, 2025, RIF of $500.
- An intake regarding a resident-to-resident altercation.
- An intake regarding a resident fall with injury.

- An intake regarding multiple care concerns for resident.
- An intake regarding an allegation of improper care of resident.
- A complaint related to family council.
- A complaint related to management.
- A complaint related to staffing.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #013 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 108 (3)
Order #014 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 140 (3) (b) (ii)
Order #002 from Inspection #2025-1419-0001 related to FLTCA, 2021, s. 24 (1)
Order #005 from Inspection #2025-1419-0001 related to FLTCA, 2021, s. 6 (7)
Order #001 from Inspection #2025-1419-0001 related to FLTCA, 2021, s. 6 (4) (a)
Order #006 from Inspection #2025-1419-0001 related to FLTCA, 2021, s. 6 (9) 1.
Order #004 from Inspection #2025-1419-0001 related to FLTCA, 2021, s. 6 (5)
Order #010 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv)
Order #007 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 40
Order #012 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 56 (2) (g)
Order #008 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 53 (1) 1.
Order #011 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 55 (2) (e)
Order #003 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 140 (2)
Order #015 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 260 (1)
Order #009 from Inspection #2025-1419-0001 related to O. Reg. 246/22, s. 55 (2) (b) (i)
Order #004 from Inspection #2024-1419-0003 related to FLTCA, 2021, s. 25 (1)

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

Medication Management
Food, Nutrition and Hydration
Whistle-blowing Protection and Retaliation
Quality Improvement
Falls Prevention and Management
Resident Care and Support Services
Skin and Wound Prevention and Management

Continence Care
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect by a personal support worker (PSW). The resident reported that during care, they requested their assistive device be left in the bathroom however, the PSW placed it outside of the bathroom. The resident also expressed that they were not pleased when the PSW placed soiled linen and incontinence products on the floor rather than the correct receptable. When the resident brought it to the PSW's attention, they stated they would clean it up after. The resident felt the PSW was not focused on their care.

Sources: A resident's clinical health records, licensee investigation and a critical incident report (CIR).

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 failed to ensure the resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care after the resident had a fall. There were two joint substitute decision makers (SDM) for the resident. One SDM was notified on the day the resident had a fall. The joint SDM was notified the next day and therefore had no opportunity for input into the resident's plan of care immediately after the fall.

Sources: A resident's clinical health record.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 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.

The licensee failed to ensure that the care specified in the plan of care for a resident was provided when a PSW did not provide assistance with their hygiene and dressing at bedtime.

Sources: Care Plan, LTC home's CIR documents, and interview with a staff.

WRITTEN NOTIFICATION: Complaints Procedure-Licensee

NC #004 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.

The licensee failed to forward a complaint to the Director regarding alleged improper care to a resident.

A resident's SDM e-mailed a written complaint to the licensee expressing concerns about the care of the resident. The Home Area Manager (HAM) received the e-mail and did not forward the written complaint to the Director.

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

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #005 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.

1. The licensee failed to ensure that the Clinical Supervisor (CS) immediately reported an allegation of improper care of a resident to the Director.

Sources: Licensee's investigation, a resident's clinical health records. and a CIR.

2. The licensee failed to ensure that the Director was immediately informed after an allegation of improper care for a resident.

An allegation of improper care was forwarded to the director as a complaint. The

licensee did not submit a CIR regarding the allegation of improper care until several days after the complaint was made. The HAM acknowledged the CIR was not immediately submitted as required by the legislation.

Sources: A CIR, and interview with a HAM.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #006 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.

1. The licensee failed to ensure that an allegation of verbal abuse from a visitor towards a resident was immediately reported to the Director.

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

2. The licensee failed to ensure that when a person who had reasonable grounds that a resident was neglected, that the suspicion and information was immediately reported to the Director. The HAM received an email from a PSW indicating their suspicion and concerns of a resident not receiving care, and meals from a coworker. This alleged neglect was reported to the Director when the alleged neglect was founded.

Sources: A CIR, internal investigation, and interview with staff.

WRITTEN NOTIFICATION: Family council assistant

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 67 (2)
Family Council assistant

s. 67 (2) In carrying out their duties, a Family Council assistant shall take instructions from the Family Council, ensure confidentiality where requested and report to the Family Council.

The licensee failed to ensure that the Family Council Assistant consistently attended scheduled meetings as requested by the Family Council. The Chief Executive Officer's (CEO) written response and interview indicated the Assistant would not be available for all meetings.

Sources: Family Council letter and the Long-Term Care Home's response, and interview with the Family Council Chair, CEO, and the Family Council Assistant.

WRITTEN NOTIFICATION: Additional training-direct care staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The licensee failed to ensure that a PSW was retrained in abuse recognition and prevention annually as required by Ontario Regulation 246/22, section 261 (2) 1.

Sources: A PSW's education records.

WRITTEN NOTIFICATION: General requirements

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented.

According to section 53. (1) 2. of Ontario Regulations 246/22, the licensee shall ensure an interdisciplinary skin and wound care program was developed and implemented in the home.

The licensee failed to ensure that measurements for a resident's area of altered skin integrity were documented as required under the licensee's skin and wound care program. Measurements of an area of altered skin integrity on the resident's skin were not documented on five out of six occasions. In addition, documentation related to continence care was recorded only once per shift on most days over a two month period.

Sources: A resident's clinical health records, the licensee's skin and wound care policy and interview with Wound Care Lead.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques when a PSW transferred a resident without a second person to assist. The resident sustained a significant skin injury and required immediate medical attention.

Sources: A resident's care plan, the licensee's internal investigation documents, and the licensee's policy: Lifts and Transfers - Safe Resident Handling Policy, and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 3.
Skin and wound care

s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids.

The licensee failed to ensure that strategies were implemented to position several residents in a manner that reduced and prevented skin breakdown, and to relieve pressure, including the appropriate use of equipment, supplies, devices, and positioning aids.

Sources: Observations in a Resident Home Area, interview with staff and external vendor.

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that a resident was provided with proper techniques to assist with eating, including safe and appropriate positioning. A PSW confirmed the resident was not in the proper position while eating. The Physiotherapist confirmed to the inspector that the mobility device in use was appropriate for the resident and that it was adjustable to support proper positioning.

Sources: Observations, a resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service

s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that a resident who required supervision with eating, was served a meal when someone was available to provide the assistance required. The resident was observed poorly positioned in bed with their breakfast tray in front of them. The Inspector returned an hour later to observe the resident in the same position and food untouched. The resident indicated they were not able to eat their breakfast because of the ketchup on their eggs and their coffee was cold.

The resident's plan of care indicated that they required supervision, which included staff to cue, encourage, or supervise to encourage them to consume their meal. The HAM indicated the resident was approved to eat in their room, but the expectation was for staff to provide supervision to the resident frequently.

Sources: Observations, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
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).

The licensee failed to ensure that Additional Precautions were followed in the Infection Prevention and Control (IPAC) program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Requirement 9.1 under the IPAC Standard, directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

At minimum, section 9.1 (f) for Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application,

removal, and disposal.

A PSW provided personal care to a resident without wearing the required PPE.

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

WRITTEN NOTIFICATION: Dealing with complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.
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,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that the response provided to a resident's SDM, who made a complaint regarding the resident's care, included 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.

A resident's SDM e-mailed a written complaint to the licensee expressing concerns about the care of the resident. The HAM received the e-mail complaint and did not immediately forward the written complaint to the Director.

The response provided to the complainant did not include an explanation to the person

who made the complaint of the outcome of the internal investigation and what was done to resolve the complaint.

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

WRITTEN NOTIFICATION: Dealing with complaints

NC #016 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 failed to ensure that two written complaints made to the licensee concerning the care of a resident provided a response which included 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.

Sources: Two CIRs, internal investigation records and interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #017 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 when documentation of medication administration for a resident did not reflect partial or refused medication.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the Medication Management system were complied with.

A Registered Practical Nurse (RPN) reported that a resident's medication was concealed in food, and the resident often refused or does not finish the food, resulting in partial doses. Observations of medication administration were completed on two occasions. The observations and interviews confirmed that the resident received only partial doses of their prescribed medications. Furthermore, record review showed that an RPN documented they administered a full dose of the medication on the MAR while the progress note indicated only a partial dose was taken. The medication policy directs that any medication refusal must be documented on the MAR and, if applicable, in the resident's progress notes.

Sources: Observations, review of a resident's clinical care record, Medication Administration and Documentation Policy, the Medication Pass Policy, and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (i)
Administration of drugs
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(i) a member of a regulated health profession and is acting within their scope of practice,

The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a member of a regulated health profession and was acting within their scope of practice. Care Support Assistants (CSAs) #105 and #128

were observed on different days administering medications to a resident by assisting the resident in consuming food in which medications had been concealed.

RPNs #107 and #119 confirmed that medications were routinely concealed in food, and that CSAs assist residents with eating this food. The HAM further confirmed that medication administration was the responsibility of registered staff.

Sources: Observations and Interviews with staff, and a resident's clinical records.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure that a medication incident involving a resident was documented and reported to the resident's SDM, the Medical Director, the prescriber of the drug and the pharmacy service provider. The Director of Resident Care (DRC) and HAM confirmed a medication incident report was not documented and no further action was completed when it was discovered that the resident had received a medicated treatment cream twice daily instead of the prescribed once daily.

Sources: Medication records.

WRITTEN NOTIFICATION: Continuous quality improvement

committee

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure their continuous quality improvement committee was composed of at least one employee of the licensee who was a member of the regular nursing staff of the home.

Sources: Review of committee meeting minutes and interview with CQI Lead.

WRITTEN NOTIFICATION: Continuous quality improvement initiative reports

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee failed to prepare a report on the continuous quality improvement initiative for the home for fiscal year ending, no later than three months after the end of the fiscal year and, therefore did not publish a copy of the report on its website.

Sources: Review of the licensee's website and interview with continuous quality improvement lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Review and revise, if necessary, internal investigation procedures related to allegations of abuse, neglect, or improper care, to ensure timely, thorough, and unbiased responses to allegations of abuse. Staff responsible for investigations, including but not limited to registered staff, supervisors, and managers, must receive in person training. Keep a written record of the revised procedure, who is responsible for initiating and/or completing investigations and signatures of staff that attended the education. Records to be provided to the Inspectors upon request.

2. Reassess the allegation of abuse reported in an identified Critical Incident Report (CIR) to ensure that the determination of the allegation as unsubstantiated is accurate, based on a thorough and objective investigation.

Grounds

The licensee failed to protect seven residents from abuse and improper care, as alleged by two PSWs and observed during morning care on two separate dates. The investigation relied on brief summaries rather than written witness statements, limiting its thoroughness. Key details, such as staff schedules, were incorrect, and staff credibility was assessed based on subjective opinion. As a result, the investigation did not adequately address serious allegations, leaving residents at continued risk of harm.

Sources: clinical health records of seven resident, a CIR, the licensee's investigation, and files, and interviews with a PSW and a Home Area Manager.

This order must be complied with by October 31, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 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 $27500.00, 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:

This is the fifth compliance order that has been issued to the licensee for failing to comply with this requirement in the past 36 months.

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 Policy to promote zero tolerance

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate PSW #134 and 135 on their prevention of abuse policy. The education should be in person and records kept of content, educators name and employee signatures. Information to be provide to the Inspectors upon request.

Grounds

The licensee failed to ensure that staff immediately reported witnessed abuse and improper care, as required by policy. Two PSWs delayed reporting incidents involving multiple residents, which compromised timely intervention. As a result, residents were placed at risk of harm or harmed due to the failure to act promptly.

Sources: the licensee's investigation, a CIR, licensee’s policy for Prevention of Abuse and an interview with a PSW and HAM.

This order must be complied with by September 1, 2025

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 #002

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:

This is the second compliance order that has been issued to the licensee for failing to comply with this requirement in the past 36 months.

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.

COMPLIANCE ORDER CO #003 Responsive behaviours

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:
1. Continuous 1:1 supervision is provided as outlined in each resident's plan of care, based on their individual assessed needs, to manage responsive behaviours and ensure safety.
2. Written instructions are created outlining 1:1 staff responsibilities, including the requirement to remain with the resident at all times. All assigned 1:1 staff will be trained on these protocols.
3. A documented plan is developed to ensure uninterrupted 1:1 coverage during staff

breaks. Ensure coverage staff are trained and aware of the resident's care needs.
4. 1:1 staffing audits are conducted twice weekly (all shifts) for 3 weeks. Document findings and corrective actions. Audits to include name and title of auditor, resident name and home area, dates and times of audits.
5. Records are maintained of the following for inspector review:
-Written 1:1 care protocols
-Break coverage plan
-Audit results and corrective actions
-Staff training records
-1:1 assignment and coverage schedules

Grounds

1. The licensee failed to ensure that the strategies in the plan of care for three residents to manage their responsive behaviours were consistently implemented. The interventions were in place to mitigate the risk associated with the residents' prior incidents of responsive behaviours.

There was an increased risk to the safety and well-being of the residents and those around them when the strategies were not implemented consistently.

Sources: Observation of one resident, internal investigation records, clinical records of three residents, and staff interviews.

2. The licensee failed to ensure that the responsive behaviour strategy identified in the care plan for a resident was consistently implemented. The intervention was to be implemented during meal service and the Inspector observed two occasions when the strategy to manage the resident's known responsive behaviour was not in place, There was a risk of increased responsive behaviours and compromised nutritional intake for the resident due to the inconsistent implementation of a prescribed behavioural and mealtime intervention.

Sources: Observations and a resident's clinical records.

This order must be complied with by October 15, 2025

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

order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #003

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:

This is the second compliance order that has been issued to the licensee for failing to comply with this requirement in the past 36 months.

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.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to

determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake: #00148295 - Follow-up #2, CO #004 / 2024-1419-0003, FLTCA, 2021, s. 25 (1), Policy to Promote Zero Tolerance of Abuse, CDD March 31, 2025. RIF $500.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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.