

Ministry of Long-Term Care

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

Central West District

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

Public Report

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| Report Issue Date: August 13, 2025 |
| Inspection Number: 2025-1279-0003 |
| Inspection Type: Critical Incident Follow up |
| Licensee: MacGowan Nursing Homes Ltd. |
| Long Term Care Home and City: Braemar Retirement Centre, Wingham |

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6-8, 11 and 12, 2025.

The following intake(s) were inspected:

- Intake: #00148061, Follow-up Order #001 related to residents' Bills of Rights;
- Intake: #00148942, related to prevention of abuse and neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1279-0002 related to FLTCA, 2021, s. 3 (1) 15.

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

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Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

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

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

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:

(i) abuse of a resident by anyone,

The licensee has failed to ensure that a witnessed incident of abuse was immediately investigated.

Sources: Critical Incident Report and interview with the DOC.
[000918]

WRITTEN NOTIFICATION: Police Notification

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

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

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Police notification

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

The licensee has failed to ensure that the appropriate police service was immediately notified of a witnessed abuse of a resident that resulted in an injury and may constitute a criminal offence.

Sources: A resident's progress notes, a Critical Incident Report and an interview with the DOC.
[000918]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #003 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:

a) Complete an interdisciplinary assessment of a resident to identify factors that could potentially trigger altercations with other residents, and identify and implement interventions to minimize that chance of further altercations. A record

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should be kept of participants, date and time, what was discussed, outcome and follow up actions taken.

b) Conduct an audit of all documented incidents of alleged, suspected or witnessed abuse to ensure police are immediately contacted for those incidents where a criminal offence may have been committed. The audit must include a record of the incidents, review of interviews/statements provided by witnesses and decision notes related to whether the incidents constitute a criminal offence for a period of two weeks. Ensure the audit is kept in the home and document any follow up action that was taken when gaps were identified.

c) Provide training to the home's management and registered staff on their Abuse Policy processes on investigating an alleged physical abuse, police notification and the reporting requirements of a criminal offence. This training should include education on what may constitute a criminal offence. A record should be kept of the participants, date of training, trainer name, and course material.

Grounds

The licensee has failed to protect a resident from abuse by another resident.

"Physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A resident abused another resident that resulted in injuries and left the resident upset.

The home's policy on Responsive Behaviours included a process on how to manage residents in situations of escalation in responsive behaviours. A resident was

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showing escalating responsive behaviours and no interdisciplinary assessment was completed after the incident to identify factors that could potentially trigger a resident's responsive behaviours to protect co-residents. Additionally, there were no follow-up or behavioural support assessment completed.

After the incident of abuse resulting in injuries, the home did not immediately initiate an investigation and police was not notified.

As a result of this incident, a lack of appropriate actions to address a resident's escalating responsive behaviours before and after the incident was identified which poses significant risk of other incidents occurring,

Sources: Home's video recording, interview with a housekeeper, an RN and the DOC, a resident's progress notes, the home's policy on Zero Tolerance of Abuse & Neglect (last revised December 13, 2024) and the home's policy on Responsive Behaviour (last revised December 17, 2024).

[000918]

This order must be complied with by September 24, 2025

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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

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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:

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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.