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

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Public Report

Report Issue Date: September 3, 2025
Inspection Number: 2025-1551-0004
Inspection Type: Critical Incident
Licensee: Corporation of the City of Cornwall
Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26 - 29, 2025 and September 2, 3, 2025

The following intake(s) were inspected:

- Intake: #00150639/CI #M529-000044-25 -related to an unexpected death of a resident.
- Intake: #00152032/CI #M529-000035-25 - related to resident to resident physical abuse.
- Intake: #00153144/CI#M529-000039-25 - related to resident to resident physical abuse.
- Intake: #00154245/CI #M529-000047-25 - related to a fall of a resident resulting in injury.
- Intake: #00154757/CI #M529-000049-25 - related to improper/incompetent care of a resident.
- Intake: #00155357/CI #M529-000052-25- related to a fall of a resident resulting in injury.

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

Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan. Specifically, the licensee has failed to ensure that a staff member ensured a resident's call bell was in reach and a fall prevention intervention was followed on a specified date.

Sources: Home's investigation notes; the resident's care plan; Interviews with staff members.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the documentation of the care provided to a resident was completed. Specifically, the documentation in Point of Care (POC) for a specific assistive device for the resident was missing on several occasions on specified dates. The Director of Care confirmed that the assistive device must be documented in POC.

Source: resident's health records, interview with staff members

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5)
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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered

the incident, and

iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 246/22, s. 115 (5).

The licensee has failed to ensure that a report in writing was submitted to the Director within 10 days of making a report to the Director of an incident under Ontario Regulation 246/22 s. (1).

Specifically, a registered staff member made an after hours report to the Director related to the unexpected death of a resident on a specified date. A written report related to the Death was not submitted to the Director related to the resident's death until a month after the specified date.

Sources: After hours report IL-014743; Critical incident M529-000044-25.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs are stored in a medication cart that is secure and locked. Specifically, the licensee failed to ensure that a registered staff member ensured their medication cart was kept locked when not being directly used or supervised.

Sources: Observation of an unlocked medication cart during the inspection.