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: August 13, 2025

Inspection Number: 2025-1551-0003

Inspection Type:
District Initiated
Complaint
Critical Incident
Follow up

Licensee: Corporation of the City of Cornwall

Long Term Care Home and City: Glen-Stor-Dun Lodge, Cornwall

INSPECTION SUMMARY

This is a modified public inspection report. The text in the finding under non-compliance (NC) #007 was modified to correct a typographical error in the previous version.

The inspection occurred onsite on the following date(s): May 30, 2025, June 2- 6, 9-13, 6-20, 23-27, and June 30, 2025; and July 2-4, 7-11, and 16-17, 2025. The inspection occurred offsite on the following date(s): July 18, 2025

The following intake(s) were inspected:

• Intake: #00135294, #00140733, and #00145389 - each related to a fall of a resident which resulted in a significant change in the resident's health condition
• Intake: #00139012 - related to the injury of a resident which resulted in a significant change in the resident's condition
• Intake: #00142236, #00142878, and #00143651 - related to outbreaks, and infection prevention and control concerns

• Intake: #00142832, #00142843, #00143506, and #00143621 - related to resident care and staffing concerns
• Intake: #00139492 - related to an incident of alleged staff-resident emotional abuse
• Intake: #00144333 - related to an incident of alleged staff-resident physical/emotional abuse
• Intake: #00145387 - related to an incident of alleged neglect of a resident by staff
• Intake: #00146158 - related to an incident of alleged resident-resident physical abuse
• Intake: #00144929 - related to a medication incident in respect of which a resident was taken to hospital
• Intake: #00142334 - related to the follow-up of CO #001 from 2025-1551-0001

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2025-1551-0001 related to FLTCA, 2021, s. 23 (2) (a)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written care plan for a resident set out clear directions to staff. Specifically, there was no direction related to the resident's specified preferences about a care task, or the related safety concerns

Sources: Resident health record, Critical Incident Report, interviews with PSWs and RPNs

WRITTEN NOTIFICATION: Requirements of program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(a) evidence-based policies and procedures;

The licensee has failed to ensure that a policy of the infection prevention and control program was implemented.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that the policies and procedures of the infection prevention and control program were implemented.

Specifically, a policy related to a transmissible condition, part of the long-term care home's infection prevention and control program, was not implemented. The required line listing was not initiated when residents on the same home area were suspected of having the same condition.

In addition, there was no indication that residents on the affected home area had been monitored for the required period of time following the identification of the last case, as required by the licensee's policy, or through other means.

Sources: relevant health care records belonging to the identified residents, including progress notes; relevant policies of the licensee, interviews with staff, including a member of the long-term care homes leadership team and others

WRITTEN NOTIFICATION: Conditions of licence

NC #003 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) #001 from inspection

#2025-1551-0001, served on March 13, 2025, with a compliance due date of April 21, 2025.

Specifically, the licensee failed to comply with CO #001 from inspection #2025-1551-0001 in the following ways:

i. After the licensee's review of existing policies and/or procedures (the policy), aspects of the updated policy- including the treatment protocol, remained unclear; and, were not implemented.

Health care providers reported varying interpretations of the updated treatment protocol and lack of clarity related to the treatment of resident contacts.

According to the staff who were interviewed, residents affected by a transmissible condition were required to be isolated until a second treatment was complete. However, when a resident was identified as being affected by the condition, this direction was not implemented.

Contrary to the licensee's policy, an interviewee stated that case contacts would be treated only if they also exhibited signs and/or symptoms of the condition.

The updated policies had not been reviewed by the Professional Advisory Committee (PAC) until after the compliance due date. Some health care providers were therefore not aware of the updates made to the licensee's policy before that time. There was also no indication that nursing staff were made aware of the updates before that time.

ii. The risk of the condition recurring, associated with resident wheelchairs, was not addressed through the policy review process.

Staff indicated that they had expected that resident wheelchairs were being cleaned as part of a terminal clean process completed by housekeeping staff whenever a resident had been affected by a transmissible condition. Another interviewee, however, indicated that housekeeping staff do not clean resident wheelchairs at any time, unless specifically requested. There was no indication that the routine cleaning of resident wheelchairs by nursing staff would address the risk of the condition recurring.

iii. The review required under the CO was completed by an interdisciplinary group which did not include a member of registered nursing staff.

Sources: relevant policies and procedures, including multiple versions of the policy in question, and other records related to compliance actions taken in response to CO #001 from 2025-1551-0001; relevant health care records belonging to a resident, including progress notes, medication administration records, and orders; and interviews with staff including a PSW, registered nursing staff, members of the leadership team, and other staff and health care providers

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 #003

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:
In the past 36 months, a CO under FLTCA, s. (23) (2) (a) was issued (2025-1551-0001) on March 13, 2025, and was not complied.

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: Transferring and positioning techniques

NC #004 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.

i) The licensee has failed to ensure that staff used safe transferring techniques when they left a resident unattended, when a transfer device was in use.

Sources: Resident health records, relevant procedure of the licensee, investigation notes, interview with a PSW, RCA, RPN, and Nursing Supervisor.

ii) The licensee has failed to ensure that a staff member used safe transferring techniques when they left another resident unattended, when a transfer device was in use.

Sources: Resident health record, relevant procedure of the licensee, investigation notes, interview with a PSW and RPN.

WRITTEN NOTIFICATION: Availability of supplies

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The licensee has failed to ensure that a resident was provided with the specialized equipment they required for their care, upon their admission.

Sources: Staff emails, equipment order forms, progress notes and interviews with relevant staff

WRITTEN NOTIFICATION: Skin and wound care

NC #006 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;

i) The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were reassessed at least weekly when it was clinically indicated.

When a resident exhibited altered skin integrity, they were not reassessed weekly, using the clinically appropriate assessment instrument, as required by the policies of the licensee's skin and wound program.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, relevant policies of the licensee; and, interviews with staff, including registered nursing staff and DOC.

ii) The licensee has failed to ensure that when another resident exhibited altered skin integrity, they were reassessed at least weekly when it was clinically indicated.

When another resident exhibited altered skin integrity, they were not reassessed weekly, using the clinically appropriate assessment instrument, as required by the policies of the licensee's skin and wound program.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, relevant policies of the licensee, and, interviews with staff, including registered nursing staff and a member of the long-term care home`s leadership team.

iii) The licensee has failed to ensure that when a third resident exhibited altered skin integrity, they were reassessed at least weekly when it was clinically indicated.

When a third resident exhibited altered skin integrity, they were not reassessed weekly, using the clinically appropriate assessment instrument, as required by the policies of the licensee's skin and wound program.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, and relevant policies of the licensee; and, resident and staff interviews, including interviews with registered nursing staff and a member of the long-term care home`s leadership team.

WRITTEN NOTIFICATION: Housekeeping

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing

practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that procedures were developed and implemented for the cleaning and disinfection of resident wheelchairs.

In accordance with section 19 (1) (a) of the Fixing Long-Term Care Act, 2021, and section 34 (1) (1) of Ontario Regulation 246/22, the licensee was required to ensure that the long-term care home's organized program of housekeeping included relevant written policies and procedures.

Over the course of the inspection, it was determined that there was no written procedure related to the cleaning and disinfection of resident wheelchairs, including no written direction related to the cleaning and disinfection of resident wheelchairs in the context of infection control and/or management of other transmissible conditions.

Sources: interviews with staff, including a PSW, and members of the long-term care home's leadership team

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 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 has failed to implement requirements of the *Infection Prevention and Control Standard for Long-term Care Homes* (the IPAC Standard) (April 2022, revised September 2023) issued by the Director with respect to infection prevention and control.

i. In accordance with Additional Requirement 4.1 (g) of the IPAC Standard (April, 2022; revised September, 2023), the licensee was required to ensure that the outbreak management system included protocols for cohorting.

Over the course of the inspection, no one who was interviewed by the inspector was able to provide the inspector with the licensee's protocol related to staff and resident cohorting.

Sources: interviews with staff and members of the long-term care homes leadership team

ii. In accordance with Additional Requirement 4.3 of the IPAC Standard (April, 2022; revised September, 2023), the licensee was required to ensure that following the resolution of each outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team conducted a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings was required to be created, to make recommendations to the licensee for improvements to outbreak management practices.

The Final Outbreak Team Meeting template had not been completed for two separate outbreaks.

The post-outbreak debrief activities had been combined with the quarterly interdisciplinary IPAC team meeting that took place after the outbreaks.

However, there was no indication that a summary of findings or recommendations to the licensee had been created by the OMT and interdisciplinary IPAC team for improvements to outbreak management practices based on an assessment of the effectiveness of IPAC practices during the relevant outbreaks.

Sources: records, including a relevant policy appendix, outbreak management team (OMT) meeting minutes, and records of the interdisciplinary infection prevention and control (IPAC) team meeting; and interviews staff and a member of the long-term care homes leadership team

iii. In accordance with Additional Requirement 9.1 (b), the licensee was required to ensure that Routine Practices were followed, including hand hygiene at the four moments of hand hygiene.

During the inspection, a staff member was observed to be moving from resident room to resident room without performing hand hygiene before entering or upon exiting the resident rooms.

Sources: observations of the inspector

iv. In accordance with Additional Requirement 10.4 (h), the licensee was required to ensure that there was support for residents to perform hand hygiene prior to receiving meals.

Over the course of the inspection, the inspector observed two separate occasions

when a resident had not performed hand hygiene before a meal; and had not been encouraged or otherwise supported by staff to perform hand hygiene prior to receiving their meal.

Sources: observations of the inspector

v) The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director, specifically standard 10.2 (c) related to assisting the residents with hand hygiene, was followed by a staff member during afternoon snack services, when four residents didn't receive assistance with hand hygiene.

Sources: observations of the inspector

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that immediate action was taken to reduce transmission, when a resident exhibited the signs and symptoms of a transmissible condition.

A resident's symptoms were treated with a medication used to treat a transmissible condition two days after the onset of the resident's symptoms. There was no indication that additional precautions were implemented, or that the resident was isolated when the symptoms were first identified or at any time before it was treated.

Additional precautions were not implemented until four weeks later.

Sources: The resident's health care records, including progress notes; and interview with a staff member

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

A resident was given medications which were not prescribed for them when a nurse administered them in error.

Sources: a review of relevant health care records belonging to the resident and the co-resident, including progress notes and medication administration records (MARs), and other relevant documents, including an internal medication incident report; and,

interview with the nurse

WRITTEN NOTIFICATION: Administration of drugs

NC #011 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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident's topical treatment was not applied in accordance with the directions for use specified by the prescriber. The resident also did not receive a dose of the same medication when it was not available to the staff for application.

Sources: a registered nurse, a member of the long-term care home's leadership team, and other staff

COMPLIANCE ORDER CO #001 Required programs

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Review and revise the Post-Fall Management Program procedure and forms to ensure that the process and documentation is completed as per the home's policy. Specifically, ensure that there is clear direction to staff on how to document ways to prevent future falls in the post-fall assessment and how to perform post-fall monitoring.

Ensure that at least one member of the nursing management team, one member of the registered nursing staff and one member of the non-registered nursing staff participate in the review. A documented record of the review and/or revision, the date of the review, the changes made if any, and who participated must be maintained.

2) Provide all registered nursing staff with education on the licensee's fall prevention and management policies including any changes resulting from 1) above. This education must include when to complete a fall risk assessment tool, what is considered a fall, post fall management, and where the post-fall huddle and assessments are to be documented.

3) Develop and complete a weekly audit to ensure adherence to the licensee's post fall management by registered nursing staff. The weekly audit will be completed on all resident home areas for a period of four weeks; and,

4) The licensee shall ensure that relevant corrective action is taken if deviations from the established protocol by staff are identified.

A written record must be kept of everything required under step (1), (2), (3), and (4) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

i) The licensee has failed to ensure compliance with the home's interdisciplinary falls prevention and management program when a resident fell and no post fall huddle was completed, as directed in the home's falls prevention program, and as confirmed through an interview.

As per FLTCA 2021 s. 11. (1) (b) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program (b) is complied with.

Sources: Interview with a nurse and member of the long-term care home's leadership team, the home's Fall Prevention and Management Program, resident's electronic health record, and the homes electronic incident report system.

ii) The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a second resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, when a second resident sustained multiple falls in a period of three and a half months, the registered staff did not include plans to prevent future falls in their post-fall assessments, nor did they create eMAR order entries for 72-hour post-fall monitoring in accordance with the home's policy.

Sources: Review of the resident's medical records and long-term care home (LTCH) documentation, and interviews with a nursing supervisor

iii) The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a third resident.

Specifically, when a third resident sustained multiple falls in a three month period, the registered staff did not include plans to prevent future falls in their post-fall assessments, nor did they create eMAR order entries for 72-hour post-fall monitoring in accordance with the home's policy.

Sources: Review of the resident's medical records and LTCH documentation, and interviews with a nursing supervisor

iv) The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a fourth resident

Specifically, when a fourth resident sustained multiple falls in a three week period, and another fall approximately two months later, the registered staff did not include plans to prevent future falls in their post-fall assessments, nor did they create eMAR order entries for 72-hour post-fall monitoring in accordance with the home's policy.

Sources: Review of the resident`s medical records and LTCH documentation, and interviews with a nursing supervisor and staff

v) The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a fifth resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, there was no EMAR order for seventy-two hours post fall monitoring and documentation created and post fall assessment documentation was not completed as per the home's policy.

Sources: The resident`s health records, Fall prevention and management program, interview with registered nursing staff, and a nursing supervisor

This order must be complied with by October 17, 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 #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:

In the past 36 months, a CO under O. Reg. 246/22, s. 53 (1) (1) was issued (2023-1551-0003) on August 14, 2023.

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 #002 Falls prevention and management

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident

has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

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

The licensee shall:

1) Provide education on the home's Falls prevention and management program, specifically home's post-fall assessment, to the home's registered nursing staff to ensure they are aware of what the assessment is and when it is required to be completed.

2) Conduct audits for all the residents, who have fallen subsequent to this order, to ensure that the Post fall assessment has been completed. Take corrective actions if the Post fall assessment has not been completed. Audits are to be conducted by a member of the nursing management team or a registered staff until the order has been complied.

Keep written records of everything required under step (1) and (2). Records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

i) The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, as confirmed during an interview.

Sources: interview with a member of the long-term cares home leadership team, the resident's electronic health record and the home's electronic Risk Management

Incident Report System.

ii) The licensee has failed to ensure that when another resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. Notably, on three separate dates, the resident fell; and, there was no post-fall assessment completed by staff.

Sources: Review of the resident`s medical records and LTCH documentation, and interviews with a nursing supervisor.

This order must be complied with by October 17, 2025

COMPLIANCE ORDER CO #003 Skin and wound care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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

The licensee shall:

1) Within ten days of receiving this compliance order, review the existing policy related to the requirement of assessing and reassessing a resident who exhibits a specific type of altered skin integrity, to ensure that the practice of conducting skin assessments in the long-term care home and the licensee's policies are consistent with each other. If inconsistencies are identified, they must be addressed. The policy must be updated, if required.

2) If the relevant policy is updated as a result of the review under step (1) of this compliance order, ensure that the updated policy is implemented by any staff member who conducts the assessment and/or reassessment of a resident's skin condition before the compliance due date.

3) Ensure that any resident who exhibits the specific alteration in skin integrity is assessed by a registered nurse, using a clinically appropriate assessment instrument that is specifically designed for skin assessment, in accordance with the licensee's policy.

4) Ensure that any resident who exhibits the specific alteration in skin integrity is reassessed by a registered nurse at least weekly when it is clinically indicated and in accordance with the licensee's policy. A clinically appropriate assessment instrument must be used when required by the licensee's policy.

5) For the purpose of this compliance order: If a weekly reassessment of a residents altered skin integrity by a registered nurse is deemed not to be clinically indicated, ensure that the rationale is clearly documented and accessible to an inspector on follow-up.

A written record must be kept of everything required under this compliance order,

until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

i) The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they exhibited altered skin integrity.

The resident`s altered skin integrity was not assessed using the clinically appropriate assessment instrument provided for by the licensee's skin and wound program.

Specifically, neither skin assessment tool identified in the licensee`s policies was used.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, and, relevant policies of the licensee; and interviews with staff, registered nursing staff and a member of the long-term care home`s leadership team.

ii) The licensee has failed to ensure that a second resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they exhibited altered skin integrity.

The second resident`s skin condition was not assessed using the clinically appropriate assessment instrument provided for by the licensee's skin and wound program. Specifically, neither tool identified in the licensee's policy were used.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, and, relevant policies of the licensee; and interviews with staff, including registered nursing staff and a member of the long-term care home`s leadership team.

iii) The licensee has failed to ensure that a third resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when they exhibited altered skin integrity.

The third resident`s skin condition was not assessed using the clinically appropriate assessment instrument provided for by the licensee's skin and wound program. Specifically, neither tool identified in the licensee's policy were used.

A staff member who was interview during the inspection was not aware of that the resident had previously exhibited the above-described skin condition, which was suspected to be a transmissible condition at the time.

During the inspection, the resident indicated that they continue to experience symptoms of the transmissible condition.

Sources: relevant health care records belonging to the resident, including progress notes and assessments, and, relevant policies of the licensee; and interviews with staff, including registered nursing staff and a member of the long-term care home`s leadership team.

This order must be complied with by September 22, 2025

COMPLIANCE ORDER CO #004 CMOH and MOH

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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

The licensee shall:

1) Develop a process for monitoring the progress of housekeeping staff on each shift and home area, and in common areas of the ground floor, during outbreaks related to enhanced environmental cleaning and disinfection requirements, to ensure that all high touch surfaces in common areas are cleaned and disinfected at least twice daily when required.

2) Ensure that there is a mechanism through which staff who are responsible for the cleaning and disinfection of high touch surfaces can communicate concerns related to capacity to complete the required task if needed, so that additional support may be provided.

3) If/when an infectious disease outbreak occurs in the long-term care home, the Support Services Supervisor and/or designate(s), must implement the processes developed under step (1) and (2). Corrective/preventative action must be taken if

required.

4) Ensure that housekeeping staff document when high touch surfaces have been cleaned and disinfected each time the task is completed. Documentation must include the date and time of task completion, as well as the name of the staff member who completed it.

A written record must be kept of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that all applicable recommendations issued by the Chief Medical Officer of Health (CMOH) were followed in the home.

Specifically, the licensee failed to ensure that all high touch surfaces in common areas of the home were cleaned and disinfected at a minimum of twice daily during two separate infectious disease outbreaks, in accordance with the CMOH's *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings* (February, 2025).

On several dates during the outbreaks, entries made by housekeeping staff on *daily touch point cleaning records* for multiple resident home areas were indicative that high touch surfaces had been cleaned and disinfected only once during a shift. In all cases, the missing entries occurred on dates when resident's on each of the home areas had been symptomatic of infection.

Gaps were also identified on *daily touch point cleaning records* used by staff during

the outbreaks to record the cleaning and disinfection of high touch surfaces on the main (ground) floor of the long-term care home, which included common areas accessible to residents in the long-term care home.

During interviews, staff reported occasions when high touch surfaces could not be cleaned and disinfected twice during the shift, as required - such as when housekeeping staff were responsible for more than one home area, and/or when other incidents occurred on the same shift which also required a response from housekeeping staff. One staff member indicated that where an entry was missing on the *daily touch point cleaning* records, it was likely that the staff member working that shift did not have time to complete the second pass of high touch surfaces.

Sources: relevant records, including the document titled *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings* (CMOH, February, 2025), daily touch point cleaning records, and housekeeping staff schedules; and interviews with staff, including housekeeping staff and supervisor, and others.

This order must be complied with by September 22, 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.