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: March 6, 2025

Inspection Number: 2025-1553-0002

Inspection Type:
Other
Critical Incident

Licensee: The Corporation of the County of Northumberland

Long Term Care Home and City: Golden Plough Lodge, Cobourg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 19, 20, 24, 26, 28, 2025 and March 3 - 6, 2025.
The inspection occurred offsite on the following date(s): February 27, 2025.

The following intake(s) were inspected:

- Two intakes regarding allegations of physical abuse of resident by a resident.
- An intake regarding an allegation of physical abuse of resident by staff.
- Three intakes regarding an allegation of verbal abuse of residents by staff.
- An intake regarding an allegation of neglect of resident by staff.
- An intake regarding the Outstanding Emergency Planning Annual Attestation.
- Three intakes regarding fall of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights
NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:
4. Every resident has the right to freedom from abuse.

1-The licensee has failed to ensure that a resident's right to freedom from abuse was upheld when a staff member was witnessed verbally and emotionally abusing a resident.

Sources: Critical Incident Report (CIR), resident's clinical record and interviews with staff.

2-The licensee has failed to ensure that two resident's right to freedom from abuse was upheld when a staff member verbally and emotionally abused the two residents on multiple occasions.

Sources: CIR, Interview with staff.

3-The licensee has failed to ensure that a resident's right to freedom from abuse was upheld when a staff member verbally and emotionally abused a resident.

Sources: CIR, the home's investigation notes and interviews with staff.

WRITTEN NOTIFICATION: Residents' Bill of Rights
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

A Critical Incident (CI) was submitted to the Director, related to abuse and neglect of a resident. The staff confirmed that safety rounds were not conducted on the resident. The resident was last checked at 1730 hours and was found in their wheelchair, in the dark at 2200 hours.

Sources: CIR, the home's Resident Safety Rounds Policy and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care
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 has failed to ensure that the care set out in the plan of care for a resident, was provided to the resident as specified in the plan.

A resident's care plan indicated, two staff are to assist with turning and repositioning every two hours when the resident is sitting in their wheelchair and in the bed; attach the call bell to the resident and remind resident to use the call bell. Resident was last checked at 1730 hours and was found in their wheelchair, in the dark at 2200 hours, with no call bell attached to the resident.

Sources: CIR, Resident's care plan and interview with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents is complied with. Specifically, when a resident was allegedly abused physically, a Head-to-Toe assessment was not performed on the resident as specified by the policy.

Sources: CIR, resident's Health Record, Prevention, the home's Reporting and Elimination of Resident Abuse Policy, and interview with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act
NC #005 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,

1- The licensee has failed to ensure that the alleged incident of witnessed verbal and emotional abuse of a resident, was immediately investigated. The home hired an external investigator to investigate the incident.

Sources: CIR, and interviews with staff.

2- The licensee has failed to ensure that the alleged incident of physical abuse of a resident was immediately investigated.

Sources: CIR, and interviews with staff.

3- The licensee has failed to ensure that the alleged incident of verbal, emotional, and physical abuse of a resident was immediately investigated.

Sources: CIR, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to 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.

The licensee failed to immediately report a witnessed verbal abuse incident to the Director when a resident was verbally abused by staff. It was reported to the Director two days later.

Sources: INFOLINE - LTC Homes After Hours, and the CIR.

WRITTEN NOTIFICATION: Skin and wound care
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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.

1- The licensee has failed to ensure that a resident's skin tear was assessed by an authorized person using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Sources: CIR, Resident's progress notes, health record and interview with staff.

2- Following an incident of abuse towards a resident they sustained an alteration in skin integrity. The Skin and Wound program indicated that the registered staff are to complete an electronic Head to Toe Assessment if there was an alteration in skin integrity. It was documented by two registered staff that the resident sustained an alteration in skin integrity but did not complete an electronic Head to Toe Assessment and should have.

Sources: Progress Notes and Assessments for a resident, the home's Skin and Wound Program.

WRITTEN NOTIFICATION: Skin and wound care
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

The licensee has failed to ensure that when a resident received an alteration in skin integrity, the skin was reassessed at least weekly by an authorized person.

Sources: CIR, a resident's progress notes and health record and interviews with staff.

WRITTEN NOTIFICATION: Police notification
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
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).

1- The licensee has failed to ensure that the alleged incident of abuse of a resident by staff, was reported immediately to police.

Sources: CIR, and interviews with staff.

2- The licensee has failed to ensure that the alleged incident of abuse of a resident by staff was reported immediately to police.

Sources: CIR, and interviews with staff.

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

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
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.

1- The licensee has failed to include analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence when making a report under subsection 27 (2) of the Act. Specifically, when the home submitted Critical Incident Report regarding abuse of a resident by staff.

Sources: CIR, and interviews with staff.

2- The licensee has failed to include analysis and follow-up action, including, the immediate actions that have been taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence when making a report under subsection 27 (2) of the Act. Specifically, when the home submitted Critical Incident Report (CIR) regarding abuse of a resident by staff.

Sources: CIR, and interviews with staff.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act
NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (2)

Licensees who report investigations under s. 27 (2) of Act
s. 112 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The licensee failed to submit a Critical Incident Report to the Director within 10 days of becoming aware of a witnessed verbal abuse incident of a resident by staff. The incident was not submitted until thirteen days later.

Sources: CIR.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act
NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

1-The home submitted to the Director, an allegation of abuse, and did not finalize the report within 10 days as required. An interview with staff confirmed they did the initial submission to the Director but failed to provide a follow up report as required within 10 days.

Sources: CIR, interview with staff.

2- The home submitted to the Director, an allegation of abuse, via the After-Hours telephone. Approximately two months later, the home was advised by the Ministry of Long-Term Care to submit a CIR within the week. The home submitted the CIR to

the Director during the inspection.

Sources: CIR.

WRITTEN NOTIFICATION: Attestation
NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee has failed to ensure the home's annual Emergency Planning Attestation form was submitted to the Director prior to December 31, 2024.

Review of the LTC.Info@ontario.ca mailbox by the Ministry of Long-Term Care Inspection Branch (MLTCIB) indicated no record of the home's annual Emergency Planning Attestation Form submission for the year 2024. The Administrator indicated the required form was not submitted for 2024. The Attestation was received on February 6, 2025.

Sources: Emergency Attestation Form signed and submitted February 6, 2025.

COMPLIANCE ORDER CO #001 Duty to protect
NC #014 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)]:

1. The Director of Care (DOC) or designate shall provide an in-person education to two Personal Support Workers on the home's policy regarding the Zero Tolerance of Abuse and Neglect of Residents. Keep a documented record of the education provided, including the date, time, training materials, names and designations of attendees, and the person delivering the training.

2. The DOC or designate shall provide an in-person education to all Registered Nurses, including agency and Management staff on the home's policy regarding the Zero Tolerance of Abuse and Neglect of Residents and the Investigation of Alleged, Suspected, or Witnessed Abuse. Ensure the training includes the process for initiating immediate investigations, timelines for completing investigations, and documentation requirements. Keep a documented record of the education provided, including the date, time, training materials, names and designations of attendees, and the person delivering the training.

3. The DOC or designate shall develop and implement a daily auditing process for a period of six weeks to ensure all reported abuse or neglect incidents are investigated immediately and immediate actions have been taken to prevent recurrence. Document each audit, including the date, the name and designation of the auditor, incidents reviewed, and any non-compliance identified. If non-compliance is identified, outline the corrective actions taken, and ensure these are documented. Then the DOC or designate shall analyze the audit findings at the end of the six-week period to identify trends, gaps, or recurring issues in the home's investigation process. Develop and implement a corrective action plan to address any gaps or delays in the investigation process. Maintain a record of the analysis and the corrective actions taken.

4. All audits and education records will be retained and made available to Inspectors upon request.

Grounds

1- The licensee failed to ensure that a resident was protected from abuse by a staff member when the resident and their family reported an incident of emotional, verbal, and physical abuse. Despite the report, the home did not investigate the incident.

“Emotional abuse” means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

“Verbal abuse” means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

“Physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain.

An incident of abuse of a resident was reported to the home. Staff confirmed that the home did not investigate the incident, and the incident was referred to an external investigator and the final report was not concluded at the time of the inspection. Staff confirmed that no actions were taken to prevent the reoccurrence until the incident was referred to the external investigator.

Failure to ensure that a resident was protected from abuse by a staff member left the resident and other residents at increased risk of being abused.

Sources: CIR, Copy of staff emails, and interview with staff.

2- A Critical Incident (CI) was submitted to the Director related to abuse and neglect

of a resident. Staff confirmed that safety rounds were not conducted on the resident. The resident was last checked at 1730 hours and was found in their wheelchair, in the dark at 2200 hours, with no call bell attached to the resident.

For the purposes of the Act and this Regulation,
"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee failed to provide the resident with the necessary care and assistance to ensure their health, safety, and well-being placed the resident at increased risk of harm.

Sources: CIR, electronic health record of a resident, interviews with staff.

3- The licensee failed to ensure that a resident was protected from abuse by staff.

An incident of witness abuse of a resident was reported to the home. Staff confirmed that the home did not complete its investigation, and that the incident was referred to an external investigator.

The management staff confirmed that the staff member in question continued to work in the same home unit where the affected resident resides, no actions were taken to prevent the reoccurrence, and the incident was referred to the external investigator and the report was not concluded at the time of the inspection.

Failure to ensure that a resident was protected from abuse by staff left the resident and other residents at increased risk of being abused.

Sources: CIR, resident's progress notes, emails, and interview with staff.

This order must be complied with by June 2, 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.