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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: April 4, 2025

Inspection Number: 2025-1701-0001

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Gilmore Lodge, Fort Erie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18 - 21, March 24 - 28, 31, 2025 and April 1 - 4, 2025.

The following intake was inspected in the Critical Incident (CI) section:

- Intake: #00135973/ CI # M635-000003-24 - Fall of resident resulting in an injury.
- Intake: #00134070/ CI # M528-000015-24/M528-000016-24 - ARI - COVID - Outbreak
- Intake: #00137835/ CI # M635-000001-25 - ARI - Outbreak
- Intake: #00139328/ CI # M635-000003-25 - Enteric - Outbreak declared

The following intake(s) was inspected in the complaint section:

- Intake: #00138097 - Complaint with concerns related to short staffing, food services and resident care and support services.
- Intake: #00138259 - Complaint with concerns related to plan of care, administration of drugs, oral care, food production, dietary services and hydration.

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The following intake(s) were completed in the inspection:

- Intake: #00139405/ CI #M635-000004-25 - Fall of resident resulting in an injury.
- Intake: #00139653/ CI #M635-000006-25 - Fall of resident resulting in an injury.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed when they no longer required an intervention and it was still present in their plan of care. A staff removed the intervention from the plan of care.

Sources: Observations of a resident, resident's clinical record, interview with staff.
Date Remedy Implemented: April 2, 2025

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)
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,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in

subsection 52 (2), or
(B) is an internationally trained nurse who is working as a personal support worker.
O. Reg. 66/23, s. 28 (1). Or

The licensee has failed to ensure that Personal Support Workers (PSW) on a specific home area received training in the administration of drugs in accordance with written policies and protocols developed for the medication management system prior to administering oxygen to a resident.

Sources: Interviews with staff, observation of a resident, a resident's clinical record.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 has failed to ensure the Substitute Decision Maker (SDM) was given an opportunity to participate fully in the implementation of the resident's plan of care. A new intervention was implemented for the resident and the SDM was not notified.

Sources: Video Footage and interview with DOC.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 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.

A) The licensee has failed to ensure that the care set out in a resident's plan of care is provided to the resident. On a specific date, the inspector did not observe a specified intervention provided for the resident that was set out in the plan of care.

Sources: observations, resident's clinical records and interview with Nutritional Manager.

B) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them when three nutritional interventions were not provided to them during meal service as specified in their plan of care.

Sources: observation, resident's plan of care, interview with staff.

C) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them on identified dates as specified in their plan of care.

Sources: A resident's clinical record, meeting minutes with staff.

D) The licensee has failed to ensure the care set out in resident's plan of care was provided to them when a type of intervention was not applied as specified in their plan of care.

Sources: Resident's clinical record, interview with DRC, CI report #M635-000003-24.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure the residents plan of care was reviewed and revised when an intervention to help manage resident's responsive behaviours was not in the plan of care. Video footage with the Director of Care (DOC) was reviewed with the intervention in use.

Sources: Video Footage, residents clinical record and interview with DOC.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #006 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 has failed to ensure that any written complaint the home received

regarding the care of a resident was submitted to the Director immediately when two written complaints received in December 2024 and one written complaint received in March 2025 were not submitted to the Director.

Sources: Written complaints dated in December 2024 and March 2025, and interview.

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs or food preferences;

The licensee has failed to ensure that the homes menu cycle included a choice of other available entrées to meet a resident's specific food preferences. During a meal service there were two available entrees. The resident disliked one of the entrée choices and was not provided with an alternative entrée option.

Sources: Observations of meal service, resident's clinical record, interview with the Nutrition Manager.

WRITTEN NOTIFICATION: Dining and snack service

NC #008 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 has failed to ensure a resident who requires assistance with eating was served a meal until someone is available to provide the assistance required. Inspector observed the resident at a meal service and was served the meal when a PSW was not available to provide the assistance that is required for the resident.

Sources: An observation, resident's clinical records and interview with the nutritional manager.

WRITTEN NOTIFICATION: Dealing with complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home

relating to written complaints regarding the care of a resident. There was no record that included the nature of the written complaints, the dates they were received, the type of action taken to resolve the complaints, the final resolutions, every date of which any responses were provided to the complainant and a description of the responses, and any responses made in turn by the complainant.

Sources: Written complaints dated December 2024 and March 2025, the home's policy titled Complaint Process, last revised October 15, 2024, interview with Director of Resident Care.

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 (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 oxygen was administered to a resident in accordance with the directions for use by the prescriber when on a specific date, the resident's oxygen was not provided to the resident according to the physician's orders.

Sources: A resident's clinical record and investigation notes.