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: June 11, 2025

Inspection Number: 2025-1553-0005

Inspection Type:
Complaint
Critical Incident
Follow up

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): June 3-6, 9-11, 2025

The following intake(s) were inspected:

- Follow-up #1 - CO #001/2025-153-0002, FLTCA, 2021 s. 24 (1), Duty to protect, CDD June 02, 2025
- Follow-up #1 - CO #001 / 2025-1553-0004, FLTCA, 2021 s. 5, Safe and Secure Home, CDD June 02, 2025
- An intake related to alleged staff to resident abuse
- An intake related to alleged resident abuse by a visitor
- An intake related to alleged staff to resident abuse
- An intake related to alleged staff to resident abuse
- An intake related to a medication administration error
- An intake related to improper care of a resident
- An intake related to alleged staff to resident abuse
- An intake related to alleged resident abuse by a visitor
- An intake related to an anonymous complaint regarding air temperatures

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1553-0002 related to FLTCA, 2021, s. 24 (1)
Order #001 from Inspection #2025-1553-0004 related to FLTCA, 2021, s. 5

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

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) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to treat a resident with dignity and respect when a staff member withheld the resident's prescribed treatment until the resident would comply with

care they did not want to do.

Sources: A Critical Incident Report (CIR), home's internal investigation file, resident's clinical record, interview with Associate Director of Care (ADOC)

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) 3.
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:
3. Every resident has the right to have their participation in decision-making respected.

The licensee failed to ensure that a resident's rights related to decision making were respected when a staff member attempted to force them to receive care against their will.

Sources: CIR, home's internal investigation file, resident's clinical record, interview with Director of Care (DOC)

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has an obligation to protect residents privacy in accordance with the Municipal Freedom of Information and Protection of Privacy Act.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the confidentiality of information and conflict of interest were complied with.

The licensee failed to protect a resident from a breach of privacy by a staff member and from a conflict of interest identified for the staff member.

Sources: CIR, home's internal investigation file, Northumberland County Confidentiality Policy, interviews with Administrator

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

1. The licensee failed to ensure that a resident was protected from emotional abuse when staff members spoke rudely to the resident.

Section 2 (1) (a) of the Ontario Regulation 246/22 defines emotional abuse as "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."

A CIR submitted to the Ministry of Long-Term Care, indicated that a resident reported that staff members spoke rudely to them. Progress notes indicated the resident was saddened by the interaction. The home's investigation determined that the interaction between staff members and the resident was founded as emotional abuse. ADOC confirmed that the emotional abuse allegation was founded.

Sources: CIR, resident's clinical records, the home's investigation notes, and interviews with ADOC

2. The licensee failed to protect resident a from verbal and physical abuse when a staff member attempted to force them to receive care against their expressed objection.

Sources: CIR, home's internal investigation file, resident's clinical record, interview with DOC

3. The licensee failed to ensure that a resident was protected from abuse by a private care giver when they were physically abused.

Sources: CIR, home's internal investigation file, resident's clinical record, interview with ADOC

4. The licensee failed to protect a resident from emotional abuse by a staff member when they withheld an prescribed treatment until the resident would comply with receiving care.

Sources: CIR, resident's clinical record, home's internal investigation file, interview with ADOC

WRITTEN NOTIFICATION: Reporting certain matters to director

NC #005 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.

1. The licensee failed to immediately report an incidence of emotional abuse of a resident by a staff member which resulted in risk of harm.

Sources: CIR, resident's clinical record, home's internal investigation file, interview with ADOC

2. The licensee failed to immediately report witnessed abuse of a resident by a private care giver.

Sources: CIR, home's internal investigation file, resident's clinical record, interview with ADOC

3. The licensee failed to immediately report an incident of abuse to the director that occurred when an incident of a staff member forcing a resident to receive care against their will was witnessed and not reported by another staff member.

Sources: CIR, home's internal investigation file, resident's clinical record, interview with DOC

4. The licensee failed to immediately report alleged verbal / emotional / financial abuse of a resident on after becoming aware of concerns expressed by a staff

member.

Sources: CIR, home's internal investigation file, interviews with Administrator

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The license failed to immediately notify resident's substitute decision-maker when they became aware of an incident of alleged, suspected or witnessed abuse by a private care provider.

Sources: CIR, resident's clinical record, home's internal investigation file, interview with ADOC

WRITTEN NOTIFICATION: Administration of drugs

NC #007 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 drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed a medication for a health concern. The prescribed directions indicated a dose to be given to the resident every 8 hours. The CIR indicated that a day shift nurse administered the medication to the resident as prescribed, but did not sign it off in the eMAR (Electronic Medication Administration Record). The oncoming evening shift nurse noted that the medication was overdue in their eMAR and administered a second dose of the same medication. A medication count on the following day revealed that a duplicate dose of the medication was administered to the resident. ADOC confirmed that the medication was not administered to the resident as specified by the prescriber.

Sources: CIR, medication incident report, investigation notes, resident's health records, interview with ADOC

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