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: October 3, 2025
Inspection Number: 2025-1553-0007
Inspection Type: 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): September 23- 26, 29, and October 1-3, 2025.

The following intake(s) were inspected:
-Three intakes related to improper care of residents.
-One intake related to neglect of a resident
-One intake related to sexual abuse of a resident by a co-resident
-One intake related to missing controlled substances

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
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) 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.

A resident's right to be free from abuse was disregarded when another resident touched their hands, put their arm around the shoulders of the resident, and touched their breasts. The home had a security guard to protect the resident from other co-residents for a specific period, however the incident occurred outside of the security guards contracted hours.

Sources: Critical Incident Report (CIR), the resident's clinical health records, interviews with Behavioural Support Ontario (BSO), Registered Practical Nurse (RPN) and Registered Nurse (RN).

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) 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 failed to protect a resident from a breach of privacy, when the resident's daughter arrived for a visit and from the hallway could see that their parent was undressed while receiving personal care from personal support worker (PSW), who confirmed they had chosen not to close the room door. The Assistant Director of Care (ADOC) described the need to fully close the room door when providing personal lower body care to the resident.

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

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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.

An allegation of sexual abuse by a resident towards a co-resident was reported to the RPN by a family member who witnessed the incident between the residents. The RPN failed to report the incident to the Director. It was not until four days after the incident, that the RN, was made aware of the incident by a family member, and a CIR was submitted to the Director.

Sources: The CIR and interviews with the RPN and RN.

WRITTEN NOTIFICATION: Menu Planning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (7)
Menu planning
s. 77 (7) The licensee shall ensure that meals and snacks are served at times agreed upon by the Residents' Council and the Administrator or the Administrator's designate. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that meals were served at times agreed upon by the Residents' Council and the Administrator or the Administrator's designate, when a resident and the ADOC confirmed that dinner meals were provided to the resident at least an hour past the scheduled serving time on two consecutive evenings.

Sources: The approved meal schedule, complaint response letter, interviews with the resident and ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that written policies and protocols developed for the medication management system to ensure the administration of all drugs used in the home was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the medication management program is complied with. Specifically, several registered staff over the period of two months, did not comply with the licensee's Documentation of Narcotics and Controlled Substances policy when several of the registered staff on several occasions, did not consistently document the administration of narcotics as required to a resident in the Medication Administration Records (MAR) records and on the Narcotic Drug Count record. The policy required registered staff to immediately document all medications administered, refused or omitted after administration on the MAR.

Sources: The CIR, clinical health records for a resident, the home's Documentation of Narcotics and Controlled Substances Policy, and interviews with the RPN and ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

Regarding a resident's hydromorphone order, there were repeated failures to complete and co-sign narcotic counts. This introduced risk of inaccurate documentation and potential medication discrepancies. The lack of proper verification may compromise medication safety, accountability, and regulatory compliance.

Sources: CIR, Narcotic Drug Count record for the resident, CareRx Narcotics and Controlled Medication Counts Policy, and interviews with the RPN and ADOC.

WRITTEN NOTIFICATION: Medical directives and orders — drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (a)
Medical directives and orders — drugs
s. 126. Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and

The licensee failed to ensure a resident's medication dosage was reviewed with the physician following the International Normalized Ration blood test (INR). The initial order specified a reduced dose for a specified period of time, but lacked instructions beyond that period. Nursing staff did not seek clarification or obtain a new order, resulting in the resident not getting that medication for ten days.

Sources: The resident's clinical health records, medical incident report, and interviews with the RPN, two RNs, ADOC, and the MD.

WRITTEN NOTIFICATION: Security of drug supply

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 3.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 246/22, s. 139; O. Reg. 66/23, s. 27.

A Critical Incident regarding missing narcotics was submitted to the Director. Upon inspection, it was determined that narcotic sheets had not been reviewed on a monthly

basis. On one occasion, hydromorphone was documented at a certain volume during a count, and later documented as zero. On another date, the narcotic sheet was signed by two RPNs, indicating no discrepancies found, despite a significant amount of hydromorphone being unaccounted for. This discrepancy was not forwarded for investigation as required by the home's policy.

Sources: CIR, Narcotic Drug Count record, Narcotics and Controlled Substances Policy, and interviews with the RPN and ADOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 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 failed to ensure that a resident received medications as prescribed. Medications, including high-alert medications, intended for one resident were mistakenly administered to another, resulting in the affected resident experiencing adverse effects.

Sources: CIR, eMAR for the resident, the homes investigation files, progress notes for another resident, CareRX Policy for The Medication Pass, and interviews with DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(b) corrective action is taken as necessary; and

The licensee failed to take corrective action following a medication error in which a

resident did not receive a specific medication for ten consecutive days. Staff education on this medication was identified as a long-term corrective measure, however, the ADOC could not confirm if the education was implemented, the recipients, or content. Nurses involved in the incident denied receiving any related training.

Sources: CIR, the home's investigation notes, and interviews with the ADOC, RPN and RN.