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: April 8, 2025

Inspection Number: 2025-1553-0004

Inspection Type:
Complaint
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): March 31, 2025 and April 1-4, 7, 8 2025

The following intake(s) were inspected:
Intake #00138588 - Critical Incident System (CIS) report related to alleged incidents of staff to resident neglect
Intake #00141060 - CIS report related to alleged staff to resident abuse
Intake #00141326 - CIS report related to an environmental emergency
Intake #00141341 - Complaint regarding resident care and safety.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
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) 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.

The licensee has failed to ensure that a number of residents were free from neglect by staff. Three residents required staff assistance with care and there was missing care documentation for a specific date. The licensee's investigation and staff interviews indicated that resident care may not have been performed at appropriate times. Failure to provide a resident with care required for their physical well-being and safety impacts their ability to live in dignity, safety and comfort.

Sources: CIS report, clinical record, the licensee's investigation notes and interviews with an Associate Director of Care (ADOC) and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 to the Director allegations of resident neglect by staff that resulted in a risk of harm to the residents. A critical incident system report related to the incident was received by the Director, one day after the date of the incident. Failure to immediately report to the Director suspicions or allegations of neglect of one or more residents impacts the promotion of zero tolerance of abuse and neglect of residents in the home.

Sources: CIS report, clinical records, and interviews with an ADOC and other staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
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,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that three residents' substitute decision makers (SDM) were notified within 12 hours of alleged incidents of resident neglect by Personal Support Worker (PSW) staff. Failure to notify a resident's SDM of an allegation of resident neglect prevents a resident's SDM from being involved in the resident's plan of care.

Sources: CIS report, clinical record, the licensee's investigation notes and interviews with an ADOC and other staff.

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

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. i.
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:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,

The licensee failed to include in a report of investigation to the Director under subsection 27 (2) of the Act the names of all residents involved in alleged incidents of resident neglect. The licensee's investigation and staff interviews identified a number of residents, however there were no residents named in the report to the Director. Failure to provide the names of residents involved in the incidents of alleged resident neglect in the report to the Director impacts the promotion of zero tolerance of abuse and neglect of residents in the home.

Sources: CIS report, the licensee's investigation notes, and interviews with an ADOC and other staff.

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

NC #005 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.

The licensee has failed to provide a final report to the Director under subsection 27 (2) of the Act within 21 days as specified by the Director. A critical incident system report was received by the Director related to alleged incidents of resident neglect. At the time of inspection, the licensee's investigation was not completed and a final report on the status of the licensee's investigation was not provided to the Director. Failure to provide the final report to the Director on the incidents of alleged resident neglect within 21 days impacts the promotion of zero tolerance of abuse and neglect of residents in the home.

Sources: CIS report, the licensee's investigation records, Reporting Requirements for Long-Term Care (LTC) Homes, interview with an ADOC.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

1) Develop and implement a written plan to ensure that a resident is monitored by

the home at all times with the exception of providing the resident with privacy when in the bathroom, to ensure safety and prevent risk of harm.

2) Retain the written plan for inspector review.

3) Develop and implement a written plan to ensure a resident is checked for specific objects upon return from every outing. Keep a written record of each check. The record should indicate date, time, who conducted the check, outcome and action taken.

4) Retain the written plan for inspector review.

5) Provide education to the resident's private companion around the resident's plan of care related to safety. Retain a record of the date and name of who delivered the education to the resident's companion.

Grounds

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

On a specific date, a incident occurred at the home that placed residents at risk of harm.

Review of a resident's clinical records noted that specified objects were accessible to the resident after the date of incident.

Additionally, Inspectors observed the resident outside unattended. A specific supervisory intervention was not present at the time.

Interviews with the RPN, a security guard and the Administrator confirmed that the resident has a number of specific supervisory interventions in place, including but not limited to, accompanying the resident outside and tracking specified objects. The security guard stated that when they take the resident outside, they are responsible to observe the resident in close proximity. Furthermore concerns have been brought forward around high risk items being discovered in the resident's possession upon returning from outings with their private companion.

Failure to ensure that the resident was supervised on the premises of the LTC home with the private companion and review of resident records of unaccounted for objects being found in the resident's possession, created an unsafe environment for the residents in the home.

Sources: clinical records, observation, interviews with an RPN, security guard and the Administrator.

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.