ORIGINAL RESEARCH

Duty to Protect? The Troubling Pattern of Legislative Noncompliance and Missed Police Involvement in Ontario's Long-Term Care Sector

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https://doi.org/10.5770/cgj.29.930

ABSTRACT

Background

Ontario's Fixing Long-Term Care Act, 2021 requires long-term care (LTC) licensees to immediately notify police of any alleged, suspected, or witnessed abuse, neglect, or other conduct that may constitute a criminal offence. This study examines compliance with mandatory police notification requirements using publicly available Ministry of Long-Term Care (MLTC) inspection reports.

Methods

We conducted a qualitative analysis with descriptive quantitative summaries of MLTC inspection reports issued in 2024. A 20% random sample of Ontario LTC homes was selected, and all associated inspection reports (N = 457) were retrieved. Using predefined keywords ("abuse," "neglect," "police"), relevant reports were identified (n = 193) and analyzed thematically to examine legislative compliance, documentation of police involvement, and enforcement responses.

Results

Twenty-one of 193 reports (10.8%) mentioned police and were the focus of our analysis. In 16 of 21 reports, there were accounts of abuse and/or neglect, including theft, fraud, and physical and sexual assault, but police were only notified and dispatched to an LTC home in 2 of the 16 reports (12.5%). The remaining 14/16 cases (87.5%) involved incidents of resident-involved abuse or neglect where police were not contacted. Four of 21 reports (19%) involved noncompliance pertaining to required qualifications and missing or falsified police record checks. The final report cited a prior, second-hand account of police involvement for alleged resident aggression.

Conclusion

This study provides the first review of compliance practices of LTC licensees in Ontario and their legal duty to report incidents of abuse, neglect, and other suspected criminal activity to police. Inconsistencies in documentation and variation in violations issued for comparable incidents suggest that these events are often addressed within regulatory or clinical frameworks, with limited documented engagement of criminal processes.

Key words: long-term care, police, mandatory reporting, inspection reports, abuse

INTRODUCTION

Abuse of older adults in long-term care (LTC) is a serious, preventable human rights and public health concern.[1] Rates of abuse are higher in long-term care homes (LTCHs) than in the community, and the greater level of frailty, cognitive impairment, and dependence of LTC residents for activities of daily living increases their vulnerability and risk of abuse.[2–4]

During the coronavirus disease 2019 (COVID-19) pandemic, abuse and neglect in Canadian LTCHs intensified,[5,6] exposing systemic failures including profit-driven models, chronic understaffing, weak regulation, and limited accountability.[7] Reports of physical and emotional abuse, dehydration, malnutrition, untreated medical needs, and neglect documented by the Canadian Armed Forces deployed to LTCHs in Quebec and Ontario triggered investigations and urgent calls for reform.[8] In Ontario, provincial audits and the LTC COVID-19 Commission found that decades of policy favouring privatization and cost containment left LTCHs understaffed and unprepared for COVID-19, resulting in preventable suffering and loss of life.[9] The exclusion of family caregivers and confinement of non-symptomatic residents further breached LTC residents' rights to participation in care, access to visitors, and substitute decision makers, and infringed upon their basic constitutional liberties.[10]

Historically, LTC in Canada has been governed primarily through provincial regulatory frameworks that emphasize administrative oversight rather than criminal enforcement. The increasing bureaucratization of LTC has been associated with excessive administrative and compliance checklists, which have been flagged as reducing time available for direct resident care while contributing to staff workload and burnout.[11,12] This study lends support to alleviating some of this administrative burden by more appropriately involving police forces to investigate crimes, which also addresses the chronic underreporting and limited prosecution of elder abuse in Canadian LTC homes.[13–15]

Under Ontario's Fixing Long-Term Care Act, 2021 (FLTCA 2021),[16] police involvement is required for screening measures, including police record checks (i.e., vulnerable sector check, or VSC) for staff and volunteers, and/or when resident abuse or neglect is suspected to be a criminal offence. For the latter, licensees must report such incidents immediately, after which the police may investigate and lay charges (FLTCA 2021, s.105). The involvement of police in this role provides a key avenue for accountability beyond regulatory enforcement, as they have the legal authority to investigate, arrest, and lay criminal charges. However, police notification and/or police involvement is not automatic for all care issues, and despite isolated media reports, coroner's inquests, public inquiries (e.g., the Wettlaufer inquiry),[17] and commissions that describe police involvement, these tend to be case-based rather than analytical or data-driven studies.

Although research on abuse and regulatory oversight in LTCHs is emerging,[18–21] no Canadian empirical studies examine the role of police in LTCHs, whether in abuse investigations, crisis response, or enforcement. The lack of empirical research in this area limits our ability to advocate for stronger criminal accountability mechanisms in LTCHs. To address this gap, this study analyzes publicly available LTC inspection reports in Ontario to examine whether documented incidents of abuse or neglect that potentially meet mandatory police reporting thresholds under Ontario's FLTCA 2021 were reported to police as required.

METHODS

Study Design

Ontario's FLTCA 2021 and its accompanying regulations (*O. Reg.* 246/22) establish mandatory standards for LTCHs and outline inspection and enforcement processes. Inspections may occur in response to complaints or reported incidents, as part of proactive compliance inspection programs, or as follow-up to previously identified noncompliance. Following each inspection, a report is issued documenting findings, including instances where no noncompliance is identified.

Section 105 of the FLTCA 2021, titled "**Police Notification"**, requires that *"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) (Appendix A). In this context, criminal misconduct is captured under the *Criminal Code of Canada*,[22] and includes a range of offences including physical or sexual assault, criminal negligence causing bodily harm, fraud, or theft.

When a licensee fails to immediately notify police of an eligible incident (see Appendix B for Glossary of Definitions of Abuse and Neglect), inspectors are to issue a written "Police Notification" violation. This noncompliance becomes part of the home's public record and may result in escalated enforcement actions, including compliance orders, follow-up inspections, or administrative monetary penalties or AMPs (see Appendix C for a glossary of inspection and penalty types).

Using a qualitative document analysis approach[23] supplemented by quantitative descriptive summaries, this study conducted a document analysis of publicly available Ministry of Long-Term Care (MLTC) inspection reports to assess the extent to which LTC licensees complied with the mandatory police notification requirement set out in section 105 of the FLTCA 2021. Document analysis is a systematic procedure for evaluating printed or electronic materials to extract meaning, identify patterns, and develop empirical insights.[23]

Data Collection

A random sample of 20% (N = 138) of LTCHs in Ontario was drawn, with 8 excluded for lacking 2024 inspection reports, resulting in a final sample of 130 LTCHs. This sample size was selected to provide a feasible yet sufficiently large set of inspection reports to identify patterns in police notification-related violations while maintaining depth for qualitative analysis. In qualitative research, sample size is guided by information richness and thematic saturation rather than statistical representativeness.[24] Accordingly, this sample represents a large, information-rich dataset for focused document analysis. Descriptive statistics were used to summarize observed patterns and provide context, not to support statistical generalization. Of these, 75 (58%) were for-profit, 34 (26%) were not-for-profit, and 21 (16%) were publicly owned (e.g., municipal) LTCHs, which aligns with the provincial ownership breakdown of LTCHs in Ontario (i.e., 57% for-profit, 27% not-for-profit, and 16% publicly owned).[25] Next, a full list of inspection reports was extracted from the MLTC online administrative database (MLTC, 2024) for each of the 130 LTCHs, resulting in 457 unique inspection reports for the 2024 calendar year, spanning January 1, 2024 to December 31, 2024. We screened out any reports that did not include the keywords "abuse," "neglect," or "police", leaving 214 reports. We then removed reports that found no noncompliance with the legislation (n = 21), leaving 193 reports. We then narrowed the sample to only those that mentioned police (also n = 21). A structured data extraction form was developed a priori and applied to all 21 reports to systematically extract report characteristics, details of alleged abuse and/or neglect, and documentation of police involvement as recorded in the inspection reports (e.g., "police

contacted" or "police dispatched"). This systematic approach enabled a structured evaluation of compliance with mandatory reporting requirements.

Table 1 breaks down our sample of included LTCHs by ownership and inspection report tally.

Analysis

NVivo 9 (Lumivero, Denver, CO, USA) and Microsoft Excel (Microsoft Corporation, Redmond, WA, USA) were used to store, code, and analyze the sample of 457 MLTC inspection reports. Reports were screened and selected using predefined keywords related to police involvement, abuse, and neglect. Both descriptive statistics and thematic analysis[26] were applied to the extracted data to characterize police notification practices across LTCHs in Ontario. Team members met weekly to review and refine codes in an iterative fashion, resolve discrepancies, revise the coding dictionary, and group refined codes into higher-level themes following thematic analysis procedures (see Figure 1 for detailed description of data collection and analysis).[26–28]

RESULTS

Of the 193 reports, police were mentioned in only 21 (10.8%). In 16 of 21 reports (76.2%), there were accounts of abuse and/or neglect, including theft, fraud, and physical and sexual assault. Despite the FLTCA 2021 requirement that licensees must immediately notify police of any potential criminal abuse or neglect involving residents, police were only notified and dispatched to an LTCH in two of the 16 reports (12.5%). One licensee immediately contacted police as required, and another contacted police the next day. In 14/16 cases (87.5%), incidents of resident-involved abuse or neglect were not reported to police. Four of 21 reports (19%) involved noncompliance pertaining to required qualifications and missing or falsified police record checks. The final report cited a prior, second-hand account of police involvement for alleged resident aggression.

Moreover, in only 10/193 reports (5.2%), a written "Police Notification" violation was issued (Table 2). In four of the 193 reports (2.1%) citing "neglect" or "abuse," written notifications were issued specifically for "Prevention of Abuse and Neglect." In all other reports, instances of abuse or neglect were cited in written notifications under different, often broader regulatory categories, such as "Duty to Protect," "Resident's Bill of Rights," or "Reporting Certain Matters to Director."

TABLE 1.
Sample by ownership breakdown and inspection report tally (N = 457)

Ownership of LTCH	*Number of LTCHs in Sample (n)*	*Number of Inspection Reports (n)*
For-profit ownership	75	265
Non-profit ownership	34	99
Municipal ownership	21	93
Total	130	457

LTCH = long-term care home.

Table 3 includes the 21 inspection reports citing "abuse" and/or "neglect" and "police" and descriptive information.

From the thematic analysis of these 21 reports, four themes developed: (i) records: screening measures and employee documentation, (ii) compliance with mandatory police reporting per Ontario's FLTCA 2021, (iii) noncompliance with mandatory police reporting: "Police Notification" violation issued, and (iv) noncompliance with mandatory police reporting: no "Police Notification" violation issued.

Records: Screening Measures and Employee Documentation

Under the FLTCA 2021, LTC licensees must obtain a police record check within 6 months of onboarding any staff or volunteers to ensure suitability and resident safety (Appendix A). In our sample, 6 of 21 inspection reports (29%) cited violations related to missing or inadequate police record checks. Only two licensees contacted police to verify discrepancies in staffing documentation.

The remaining four licensees were issued written "Police Notification" violations for failing to notify police of missing police record checks (or VSCs). At LTCH-016, inspectors issued a written "Police Notification" violation upon arriving at an LTCH for a separate improper care allegation and finding "*staff dressed in street clothes, wearing no identification, seated outside of various resident rooms. In the course of conversation, it was identified that these staff hired to conduct 1:1 monitoring of residents had not completed vulnerable sector checks.*"

Four of the six screening violations (66.7%) involved private staffing agencies contracted to provide care or security services. In these cases, inspectors documented licensees hiring agency workers without required qualifications (Table 3: LTCH-010) or accepting falsified records from agencies or their workers (Table 3: LTCH-015; LTCH-019). In some cases (e.g., LTCH-009), screening violations were discovered only after agency staff were implicated in improper care, resident injuries, or abuse. In all, written notifications and/or compliance orders required licensees to implement new procedures for agency staff.

Although contracted agencies were the source of screening failures in four of six cases (66.7%), only one inspector identified the agency provided in their inspection report:

The home used an agency, …, for one-to-one staff. There were no records of screening measures for these staff in the home. DRC #108 said that they entrusted the agency to screen staff, and that there was no process implemented at the time for the home to review this information. It was discovered that all agency staff did not have a completed vulnerable sector check as required (LTCH-010).

Even when more serious compliance orders were imposed, details about follow-up enforcement or charges were often

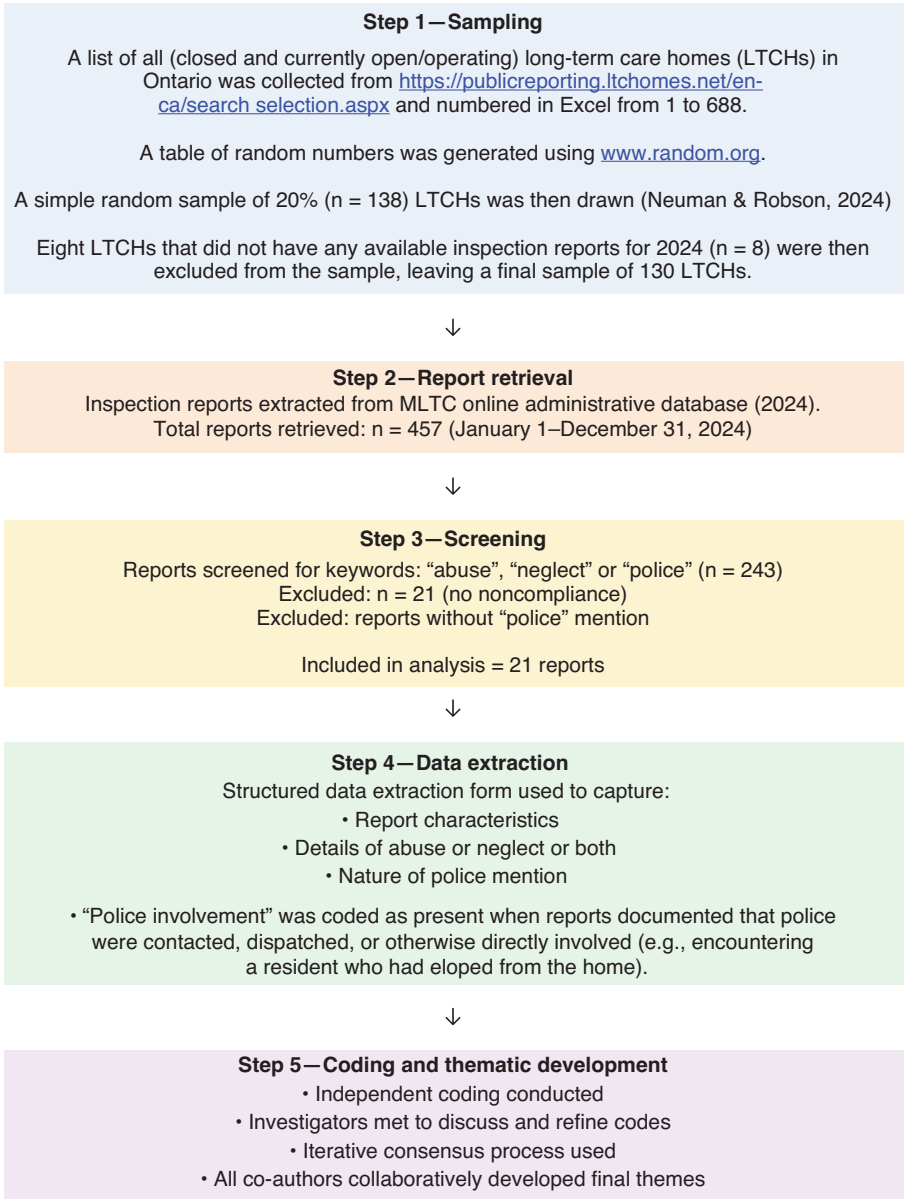

FIGURE 1. Data Collection and Analysis Flow Diagram. MLTC = Ministry of Long-Term Care

TABLE 2.
LTC licensees levied with "*Police Notification*" (i.e., failure to notify) noncompliance

LTC Licensee	*Inspection Date and Report Number*
1. LTCH-001	November 12 (2024-1192-0003)
2. LTCH-003	February 16 (2024-1312-0001)
3. LTCH-005	March 14 (2024-1323-0001)
4. LTCH-006	September 24 (2024-1100-0004: A1)
5. LTCH-007	March 19 (2024-1710-0001: A1)
6. LTCH-009	November 25 (2024-1193-0004)
7. LTCH-010	May 15 (2024-1117-0003)
8. LTCH-011	July 9 (2024-1502-0002)
9. LTCH-013	April 25 (2024-1022-0001)
10. LTCH-018	July 16 (2024-1363-0004)

LTC = long-term care; LTCH = long-term care home.

missing, even though the conduct described in the inspection reports may meet elements of Criminal Code offences such as fraud (s. 380), uttering forged documents (s. 368), forgery (s. 366), or falsifying employment records (s. 398).

Compliance with Mandatory Police Reporting per Ontario's FLTCA 2021

Despite the FLTCA 2021 requirement that LTCHs immediately notify police of resident-involved abuse or neglect that may constitute a criminal offence, only one LTCH in our sample of 21 fully complied with this obligation.

Here, police were contacted following multiple incidents of sexual abuse by a resident designated "1:1 high intensity" (LTCH-014). In this incident, police were called after the resident in question entered another resident's room and

refused to open the door; however, "*the residents opened the door before the police arrived"* (p. 23).

Noncompliance with Mandatory Police Reporting: "Police Notification" Violation Issued

Although 16 of 21 (76.2%) reports documented abuse or neglect that met the FLTCA 2021 threshold for mandatory police reporting, in only 10 of 193 reports (5.2%) were LTCHs issued "Police Notification" violations (Table 3). The 16 reports are unique inspection reports, as some of the inspection reports did come from the same LTCH (LTCH-006 and LTCH-010 each had two unique inspection reports).

Enforcement was inconsistent, both across LTCHs and within the same inspection, resulting in similar incidents being treated differently. Some LTCHs were issued "Police Notification" violations for resident-to-resident altercations or staff-to-resident abuse, while comparable or more severe cases involving staff-perpetuated resident abuse, financial exploitation, and other criminal-level neglect did not trigger this violation. Even for the LTCHs that did report eligible instances to police, delays in reporting led to "Police Notification" violations for some LTCHs.

Among case examples that illustrate these inconsistencies, LTCH-011 was issued a "Police Notification" violation for failing to report an incident of resident-to-resident abuse; however, a separate incident of staff-to-resident abuse in the same report did not result in a similar violation.

Similarly, LTCH-005 received a single "Police Notification" violation in a 68-page report documenting multiple incidents of serious abuse and neglect. The cited violation involved resident neglect leading to hospitalization that "could have been avoided with proper care" (p. 35). The same report described two other similar incidents—a resident who was hospitalized from neglect and died 9 days later, and another who fell out of a mechanical lift and was hospitalized with a significant injury—yet no "Police Notification" violations were issued for either of these incidents. The administrator for this LTCH also indicated to the MLTC inspector that "*they were not aware of the requirement to report alleged neglect"* (p. 35).

At LTCH-003, a verbal altercation between two residents was reported to police, but not until the day after the incident, thus triggering the "Police Notification" violation. Police were also dispatched to this LTCH to speak with the resident responsible, as this was their second alleged incident of verbal abuse.

At LTCH-009, failing to report alleged staff-to-resident physical abuse resulted in the "Police Notification" violation. However, in the same inspection, a separate incident was treated differently: police located a missing resident who had eloped from the LTCH and transported them to hospital with "*sustained injuries*," yet this was classified only as a "*Responsive Behaviours*" violation (pp. 14, 16). The report does not say whether the LTCH notified police about the resident's disappearance or where the resident was found. Despite the resident having "*several documented attempts to elope prior to this incident*" (p. 15) and despite the inspector noting several missed 30-minute safety checks in the Dementia Observation System (DOS) for this resident (p. 15), the home was not cited for failing to notify police of potential neglect leading to injury, nor did the inspector issue a more specific "Prevention of Abuse and Neglect" violation.

Inspection reports involving resident financial abuse also led to "Police Notification" violations for licensees failing to report these incidents to police. At LTCH-010, the inspector identified "*misappropriation of resident monies by a staff member*" (p. 20), yet police were not notified, and the report provides no details on the staff member and any resulting charges (pp. 14, 20).

At LTCH-013, a written "Police Notification" violation was issued because staff-to-resident physical abuse causing injury was not reported to police, and the same written notification was issued for a resident-to-resident altercation causing injury at LTCH-006. The latter incident also resulted in the largest AMP in our sample ($16,500). AMPs, intended as a more serious penalty for repeated noncompliance with compliance orders within a 3-year period, were disproportionately applied to resident-to-resident abuse. Of 457 inspection reports, three of the four AMPs issued involved resident-to-resident incidents.

Noncompliance with Mandatory Police Reporting: No "Police Notification" Violation Issued

The remaining inspection reports included alleged and verified instances of resident neglect, abuse, or other criminal conduct, but none resulted in violations for failing to comply with mandatory reporting requirements. Inspectors frequently issued unrelated or less-serious noncompliance findings despite clear indicators that mandatory reporting to police was required.

In one report (LTCH-006), the inspector went so far as to state that an incident of staff-to-resident physical abuse constituted "*a criminal offence and police should have been called but were not*" (p. 7-8), yet no written "Police Notification" violation was issued to the licensee.

In another report, multiple instances of improper care, unauthorized restraint use, and neglect resulting in serious skin and wound issues failed to trigger "Police Notification" violations. In one case, a newly admitted LTCH resident with a stage 1 pressure wound that deteriorated to stage 4 within a "few months" was neither reported to police nor issued the required violation. The incident was also classified as a "Skin and Wound Care" violation rather than "Prevention of Abuse and Neglect" (LTCH-017). Similarly, a verified incident of staff-resident neglect at LTCH-006 did not result in a written "Police Notification" violation and was further classified as a noncompliance under the "Residents' Bill of Rights" rather than the "Prevention of Abuse and Neglect."

Additional accounts of resident financial abuse also failed to produce the associated written violation for mandatory reporting. One report confirmed "*financial abuse has occurred towards the resident*" when an employee accepted "*gifts or gratuities from residents*" (LTCH-010, p. 21). Another verified case involved a staff member stealing

cigarettes from a resident over a period of months (LTCH-009). A further report detailed the "misuse" of a resident's personal TV and landline, resulting in $200.00 in unauthorized charges for "movies and international calls" (LTCH-020). Although the report described this last incident as a "failure to immediately report the alleged financial abuse to the Director," the inspector issued a violation for "Reporting Certain Matters to Director," with no mention of police or criminal charges.

At LTCH-004, police were notified of an incident of sexual abuse of a resident with a cognitive impairment; however, a 3-day delay in reporting the incident failed to produce a "Police Notification" violation despite other LTCHs in our sample being issued one for similar or shorter delays in reporting. Moreover, the delay in reporting was noted in the inspection report as due to "*the close relation of the alleged abuser with the resident*" (p. 2).

At one LTCH, the inspector issued a written violation under "involvement of resident etc." instead of Police Notification", even though the resident had explicitly requested that the police be called. In the report (LTCH-002), the inspector notes that "*staff did not contact the police to report an allegation of assault as requested by the resident*" (p. 2).

Across these reports, inspection reports rarely documented whether criminal charges were considered or whether matters were referred to police, even in cases describing conduct that could potentially engage Criminal Code offences such as fraud, assault, or failure to provide the necessaries of life. Across the reviewed inspection reports, documentation of police notification was infrequent and varied, and serious incidents were not consistently accompanied by documented police involvement.

DISCUSSION

Our study examined the extent to which LTC licensees in Ontario complied with the legal duty to immediately report alleged, suspected, or witnessed resident-involved abuse or neglect that may constitute a criminal offence. Results showed that licensees rarely (3 of 193 inspection reports) complied with mandatory police reporting requirements across a range of eligible incidents. Of the 457 inspection reports sampled for 2024, police were referenced in only 21 reports involving either falsified or missing staff and volunteer records and documentation (e.g., police record checks), or certain incidents of abuse and neglect. All 21 reports described events that should have triggered mandatory police notification; yet written violations for failing to notify police (i.e., "Police Notification") were often absent, with no rationale provided. Absent was any discussion of whether police involvement was considered after the fact by either the licensee or the inspector. Notably, although staff-driven misconduct was more frequently identified in inspection reports, AMPs were more commonly issued in resident-to-resident incidents. This pattern raises questions about enforcement priorities, particularly where staff-related conduct may engage potential criminal liability. Taken together, these findings suggest that mandatory police notification requirements may be enforced inconsistently, raising concerns about transparency and accountability in cases involving potential criminal conduct. This gap reveals a disconnect between legislative mandates and the realities of enforcement practices in the LTC sector.

Our findings extend prior inspection-based research by examining what occurs after abuse, neglect, and other potentially criminal incidents are identified.[18–21] In multiple inspection reports describing incidents such as theft, fraud, assault, or neglect, documentation of police involvement was minimal or absent. This highlights a major gap between the detection of criminal harm and the enforcement of mandatory external reporting requirements, indicating that inspection-level identification does not reliably translate into law enforcement engagement.

Given that most LTC residents in Ontario live with significant cognitive and/or physical vulnerabilities and may not be able to report harm,[29] such findings raise serious concerns about their safety in LTCHs. Robust, transparent, and enforced reporting mechanisms are essential. That said, variability in inspection terminology and narrative detail, as well as the specific violations issued for often comparable incidents, echo longstanding criticisms of Ontario's oversight, inspection, and enforcement regime in LTC. A 2023 investigation by Ontario's provincial Ombudsman found that MLTC inspectors have, in certain cases, exercised discretion in a way that potentially delayed or avoided more serious penalties being issued to LTC licensees.[30] In our study, inspectors often categorized incidents under broad regulatory headings (e.g., "Duty to Protect," "Resident's Bill of Rights") instead of using the more direct "Prevention of Abuse and Neglect" violation. It remains unclear whether police reports were triggered after inspection reports first flagged criminal incidents, and, if so, this raises additional questions about the role MLTC inspectors play in reporting crimes, should operators fail to do so per their legislated requirements.

This practice obscures the true prevalence and severity of abuse in LTC, minimizes the visibility of incidents that may warrant police intervention, and reduces the likelihood that licensees will face AMPs or other consequences. Standardized templates, mandatory fields indicating police notification, and uniform criteria for coding potentially criminal offences are needed to strengthen the reliability of inspection data and enable consistent detection of systemic risks. Future research should more directly examine inspection report quality and where improvements and standardizations may be warranted.

A second issue is chronic under-investment in staffing and training. Insufficient funding, inadequate staffing, and limited professional development for dementia care, behavioural management, and legal/ethical reporting obligations[31–33] mean staff may not recognize when incidents rise to the level of criminal offences or when they require mandatory reporting. This lack of clarity fosters conditions that lead to inconsistent understanding, application, and

TABLE 3 (part 1 of 5).
2024 MLTC inspection reports (N = 21) citing "abuse" and/or "neglect" and "police"

Inspection Report Details *Inspection Type	*Enforcement Actions*	*Nature of Police Mention*	*Police Involvement*	*Ownership*
LTCH-001 Urban *Critical Incident	WRITTEN NOTIFICATIONS (3): Policy to Promote Zero Tolerance; Reporting Certain Matters to Director; ***WRITTEN NOTIFICATION: Police Notification***	Police mentioned in the context of *not* being notified of an alleged incident of staff-to-resident physical abuse.	None	For-profit
LTCH-002 Urban *Critical Incident	WRITTEN NOTIFICATIONS (5): Involvement of Resident, etc.; Responsive Behaviours (×2); Licensees who Report Investigations Under s. 27 (2) of FLTCA, 2021; Reports Regarding Critical Incidents	The licensee failed to contact the police to report an allegation of assault as requested by the resident.	None	For-profit
LTCH-003 Rural *Critical Incident	WRITTEN NOTIFICATIONS (4): Plan of Care - Clear Directions to Staff; Plan of Care; Responsive Behaviours; ***WRITTEN NOTIFICATION: Police Notification*** *(police were notified, but the delay in notification resulted in the violation).*	Police mentioned in the context of not being notified immediately of an alleged incident of resident-to-resident verbal abuse. Police dispatched to LTCH the next day.	Police dispatched to LTC to speak to a resident after a second incident of alleged verbal abuse by a resident.	For-profit
LTCH-004 Urban *Critical Incident	WRITTEN NOTIFICATIONS (2): Reporting Certain Matters to Director; Reporting and Complaints	Police mentioned in the context of being informed of an incident of alleged sexual abuse of a resident with cognitive impairment. Police notified 3 days after incident "because of the close relation of the alleged abuser with the resident" (p. 2).	None	For-profit
LTCH-005 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (21): Plan of Care; when reassessment, revision is required; Duty to Protect; Reporting and Complaints (×2); Plan of Care; Care Conference; Care Plans and Plans of Care; Falls Prevention and Management; Skin and Wound Care (×2); Pain Management; Altercations and Other Interactions; Hazardous Substances; Infection Prevention and Control Program; Notification Regarding Incidents; ***WRITTEN NOTIFICATION: Police Notification***; Licensees who report investigations under s. 27 (2) of FLTCA, 2021; Obtaining and Keeping Drugs (×2); COMPLIANCE ORDERS (8); Plan of Care (×2); Transferring and Positioning Techniques; Skin and Wound Care (×2); Infection Prevention and Control Program (×2); *Prevention of Abuse and Neglect.*	Police mentioned in the context of not being notified of an incident of neglect leading to hospitalization.	None	For-profit
LTCH-006 Urban *Complaint, Critical Incident, Follow-up	WRITTEN NOTIFICATIONS (6): Duty of Licensee to Comply with Plan; *Prevention of Abuse and Neglect*; Policy to Promote Zero Tolerance; Binding on Licensees; Infection Prevention and Control Program (×2)	Police mentioned in the context of *not* being notified of an alleged incident of staff-to-resident physical abuse. Note: The Assistant Director of Nursing (ADON) stated the incident constituted a criminal offence.	None	For-profit

Note: ***Blue*** indicates a written "Police Notification" violation; ***red*** indicates an administrative monetary penalty.
FLTCA = Fixing Long-Term Care Act; LTC = long-term care; LTCH = long-term care home; VSC = vulnerable sector check; NC = non-compliance.

TABLE 3 (part 2 of 5).
2024 MLTC inspection reports (N = 21) citing "abuse" and/or "neglect" and "police"

Inspection Report Details **Inspection Type*	*Enforcement Actions*	*Nature of Police Mention*	*Police Involvement*	*Ownership*
LTCH-006 Urban *(A1) Critical Incident, Follow-up	WRITTEN NOTIFICATIONS (2): Residents' Bill of Rights; ***WRITTEN NOTIFICATION: Police Notification*** COMPLIANCE ORDERS (1): Duty to protect (#001) **AMP (1): $16,500.00 (related to CO #001)**	Police mentioned in the context of *not* being notified of an alleged incident of resident-to-resident physical abuse.	None	For-profit
LTCH-007 Urban *(A1) Complaint, Critical Incident, Follow-up	WRITTEN NOTIFICATIONS (4): Administration of drugs; ***WRITTEN NOTIFICATION: Police Notification;*** Conditions of licence Non-Compliance (NC) #003; Conditions of licence (NC #004) **AMP (2): $1100.00 (Related to NC#003** *from prior 2023 Compliance Order: 2023-1710-0006);* **$1100.00 (Related to NC#004).**	Police mentioned in the context of *not* being notified of an alleged incident of resident-to-resident physical abuse resulting in injury.	None	Municipal
LTCH-008 Urban *Critical Incident	WRITTEN NOTIFICATIONS (2): Reporting Certain Matters to Director; Doors in a Home COMPLIANCE ORDERS (3): Plan of Care; Duty to Protect; Policy to Promote Zero Tolerance	Police mentioned in the context of *not* being notified of an alleged incident of staff-to-resident physical abuse.	None	Municipal
LTCH-009 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (9): Residents' Rights (pertaining to stolen cigarettes representing financial abuse of resident by a staffer); Reporting Certain Matters to Director; Falls Prevention and Management; Skin and Wound Care; Responsive Behaviours; Infection Prevention and Control Program; ***WRITTEN NOTIFICATION: Police Notification*** *(for not reporting staff-to-resident physical abuse)*; Administration of Drugs; Hiring Staff, Accepting Volunteers COMPLIANCE ORDERS (2): Responsive Behaviours (×2)	Police mentioned in three contexts: *1. Not being notified in the context of staff-to-resident physical abuse,* 2. Missing VSC documents for a registered practical nurse (RPN) involved in one of the above incidents 3. A missing resident was found by police and taken to the hospital.	Police found a missing and injured resident and transported them to the hospital.	For-profit
LTCH-010 Urban *Critical Incident	WRITTEN NOTIFICATIONS (2): Trust Accounts; Medication Administration COMPLIANCE ORDERS (3): Screening Measures; Training; Qualifications of Personal Support Workers (PSWs)	Police mentioned in the context of missing police record checks for all agency workers from a particular contracted agency. The licensee failed to ensure agency staff successfully completed a Personal Support Worker (PSW) program.	None	For-profit
LTCH-010 Urban *Critical Incident	WRITTEN NOTIFICATIONS (6): Licensee Must Comply (NC#001); Trust Accounts; Complaints Procedure - Licensee; Dealing with Complaints; Exceptions; Chief Medical Officer of Health (CMOH) and Ministry of Health (MOH) COMPLIANCE ORDERS (2): Licensee Must Investigate, Respond and Act; ***WRITTEN NOTIFICATION: Police Notification***; Reporting Certain Matters to Director; Trust Accounts; Duty to Protect **Administrative monetary penalty (AMP): 1** **$5500.00 (related to NC #001)**	Police mentioned in the context of missing police record checks and financial abuse. The home investigated concerns related to alleged financial abuse from a staff member toward a resident, resulting in a police notification violation and AMP related to NC #001.	None	For-profit

Note: ***Blue*** indicates a written "Police Notification" violation; ***red*** indicates an administrative monetary penalty.
FLTCA = Fixing Long-Term Care Act; LTC = long-term care; LTCH = long-term care home; VSC = vulnerable sector check; NC = non-compliance.

TABLE 3 (part 3 of 5).
2024 MLTC inspection reports (N = 21) citing "abuse" and/or "neglect" and "police"

Inspection Report Details **Inspection Type*	*Enforcement Actions*	*Nature of Police Mention*	*Police Involvement*	*Ownership*
LTCH-011 Urban *Critical Incident, Complaint	WRITTEN NOTIFICATION (12): Duty of Licensee to Comply with Plan; Plan of Care; Policy to Promote Zero Tolerance of Abuse; Reporting Certain Matters to Director; Policies, etc., to be Followed, and Records; Responsive Behaviours; Infection Prevention and Control Program; ***WRITTEN NOTIFICATION: Police Notification***; Licensees who Report Investigations under s. 27 (2) of FLTCA, 2021; Orientation (×2); CMOH and MOH COMPLIANCE ORDER (2): Altercations and Other Interactions Between Residents (#001); Infection Prevention and Control Program (#002). **AMP (1):** **$1100.00 (related to compliance order #001)**	The licensee failed to notify the appropriate police service in response to alleged resident-to-resident abuse that may have constituted a criminal offence.	None	Non-profit
LTCH-012 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (30): Specific Duties Regarding Cleanliness and Repair; Specific Duties regarding Cleanliness and Repair; Required Programs; Right to Freedom of Abuse; Plan of Care; Notifications Regarding Incidents (×2); Retraining; Reporting Certain Matters to the Director; Duty of the Licensee to Comply with the Plan; Safe Storage of Drugs; Absences; Licensee to Stay in Contact; Medication Management Systems; Retraining; Licensee Must Investigate, Respond, and Act; Dining and Snack Services (×3); Dietary Services; Security of Drug Supply; Behaviours and Altercations; Documentation; Right to Quality Care and Self-Determination; Windows; Hazardous Substances; Restraining by Administration of Drug, etc., Under Common Law Duty Regarding: NC #027; Restraining by Administration of Drug, etc., Under Common Law Duty NC #027; Restraining by Administration of Drug, etc., Under Common Law Duty NC #027; Restraining by Administration of Drug, etc., Under Common Law Duty NC #030; Falls Prevention and Management; Compliance with Manufacturers' Instructions COMPLIANCE ORDERS (10): Trust Accounts; Personal Items and Personal Aids; Responsive Behaviours; Altercations and Other Interactions Between Residents; Duty to Protect; Doors in a Home; Infection Prevention and Control Program; Policy to Promote Zero Tolerance; Food Production; Dining and Snack Service	Police mentioned in the context of *not* being notified of an alleged incident of resident-to-resident abuse.	None	For-profit
LTCH-013 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (4): Maintenance Services; Hazardous Substances; Infection Prevention and Control Program; ***WRITTEN NOTIFICATION: Police Notification***	Police mentioned in the context of *not* being notified of an alleged incident of staff-to-resident physical abuse.	None	For-profit

Note: ***Blue*** indicates a written "Police Notification" violation; ***red*** indicates an administrative monetary penalty.
FLTCA = Fixing Long-Term Care Act; LTC = long-term care; LTCH = long-term care home; VSC = vulnerable sector check; NC = non-compliance.

TABLE 3 (part 4 of 5).
2024 MLTC inspection reports (N = 21) citing "abuse" and/or "neglect" and "police"

Inspection Report Details **Inspection Type*	*Enforcement Actions*	*Nature of Police Mention*	*Police Involvement*	*Ownership*
LTCH-014 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (8): Laundry Service; Plan of Care; Specific Duties Regarding Cleanliness and Repair; Policy to Promote Zero Tolerance; Reporting Certain Matters to Director; Availability of Supplies; Responsive Behaviours; Licensees who Report Investigations under s. 27 (2) of FLTCA, 2021. COMPLIANCE ORDERS (3): Duty to Protect: The Licensee has Failed to Protect Multiple Residents from the Sexual Behaviours of a Resident; Plan of Care (×2)	Police mentioned in the context of resident-to-resident physical and sexual abuse.	Police dispatched to LTC to separate residents barricaded in room together.	For-profit
LTCH-015 Urban *Complaint	WRITTEN NOTIFICATION (4): Training; Hiring Staff, Accepting Volunteers; Staff Records (×2) COMPLIANCE ORDERS (3): Qualifications of Personal Support Workers (PSWs); Infection Prevention and Control Program; Hiring Staff, Accepting Volunteers	Police mentioned in the context of missing and/or falsified police record checks (VSC) for staff.	Police service confirmed via e-mail that one contracted staffer falsified their VSC documents, two staffers' VSCs were completed by a service not authorized to conduct police record checks, and another agency staffer had a criminal record check which did not include a VSC.	Non-profit
LTCH-016 Urban *Critical Incident and Follow-up	WRITTEN NOTIFICATIONS (9): Safe and Secure Home; Plan of Care (×2); Reporting Certain Matters to Director; Communication and Response System; Compliance with Manufacturers' Instructions; Required Programs; Responsive Behaviours; Reporting and Complaints COMPLIANCE ORDERS (5): Training; Infection Prevention and Control Program (×2); Hiring Staff, Accepting Volunteers; Records, Where Kept	Police mentioned in the context of missing police record checks for agency workers.	None	Municipal: -managed by Sienna Senior Living (for-profit)
LTCH-017 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (7): Plan of Care; Policy to Minimize Restraining of Resident; Skin and Wound Care (NC #003); Skin and Wound Care (NC #004); Infection Prevention and Control Program; Reports Regarding Critical Incidents; Additional Training - Direct Care Staff (NC #007) COMPLIANCE ORDERS (4): Requirements on Licensee Before Discharging a Resident; Additional Training - Direct Care Staff (NC #009); Additional Training - Direct Care Staff (NC #010); Additional Training - Direct Care Staff (NC #011)	Police mentioned in the context of a second-hand note written by the LTCH's medical director for a *prior* undated police-involved incident involving an allegedly aggressive resident.	None	For-profit

Note: ***Blue*** indicates a written "Police Notification" violation; ***red*** indicates an administrative monetary penalty.
FLTCA = Fixing Long-Term Care Act; LTC = long-term care; LTCH = long-term care home; VSC = vulnerable sector check; NC = non-compliance.

TABLE 3 (part 5 of 5).
2024 MLTC inspection reports (N = 21) citing "abuse" and/or "neglect" and "police"

Inspection Report Details **Inspection Type*	*Enforcement Actions*	*Nature of Police Mention*	*Police Involvement*	*Ownership*
LTCH-018 Urban *Complaint, Critical Incident	WRITTEN NOTIFICATIONS (7): Resident Bill of Rights; Safe and Secure Home; Reporting Certain Matters to Director; Falls Prevention and Management; Skin and Wound Care; Responsive Behaviour; ***WRITTEN NOTIFICATION: Police Notification*** *(delayed notification)* COMPLIANCE ORDER (1): Skin and Wound Care	Police mentioned in the context of *not* being immediately notified of an incident of staff-to-resident neglect. Police were notified "a number of days after the Licensee became aware of the incident" (p. 9).	None	For-profit
LTCH-019 Urban *Complaint	WRITTEN NOTIFICATION (1): Staff Records COMPLIANCE ORDERS (3): Orientation; Infection Prevention and Control Program; Hiring Staff; Accepting Volunteers	Police mentioned in the capacity of (i) missing police record checks for agency workers and (ii) falsified police record checks for agency workers.	Communication with police forces to confirm that a staffing agency provided falsified police record checks (i.e., vulnerable sector checks/ VSC documents) for agency staff.	Municipal

Note: ***Blue*** indicates a written "Police Notification" violation; ***red*** indicates an administrative monetary penalty.
FLTCA = Fixing Long-Term Care Act; LTC = long-term care; LTCH = long-term care home; VSC = vulnerable sector check; NC = non-compliance.

documentation of mandatory reporting violations, ultimately undermining resident safety.

Research shows that police frequently respond to older adults with complex medical and social needs, yet many do not feel knowledgeable about aging-related health.[34,35] These findings indicate that police may benefit from targeted education and training with respect to their interactions with older adults.[34,35] Interprofessional collaborations between police and healthcare providers (e.g., LTC staff) can strengthen these competencies and improve the identification and response to elder abuse.[34,36] Policing has largely been viewed as separate from healthcare, a factor that limits such collaborations.[37] However, integrated police–healthcare collaborations can clarify legal thresholds, evidentiary standards, and documentation requirements essential for successful investigations.[2,36] Specialized elder abuse units contribute trauma-informed, resident-centred investigative approaches, including communication techniques tailored for older adults living with cognitive impairment.[38–40] These initiatives are shown to increase staff confidence when engaging with police and enhance safety responses during high-risk incidents such as resident-to-resident aggression.[2]

Police engagement should be seen not as punitive, but as a safeguard that protects residents, supports staff in navigating legal and evidentiary requirements, and reinforces shared responsibility across care and justice systems. Constructive, cross-sector collaboration offers a path to enhance resident safety, strengthen public trust, and ensure that criminal acts in LTC are addressed appropriately.

Overall, these findings reveal an LTC oversight system in which legislative expectations are not matched by enforcement practices, where documentation is inconsistent and often incomplete, and where residents may be left unprotected due to uncertainty around when police notification and involvement are required. Addressing these issues will require additional training, government commitment, and regulatory reform, with a focus on resident safety, security, and protection in LTC. Appropriate police involvement can signal that elder abuse is a matter of public safety and criminal accountability, helping to address the widespread abuse and neglect that occurs in the LTC sector.

Limitations

This study only analyzed a sample of Ontario LTCH inspection reports for the 2024 calendar year. Future studies can expand samples to include more LTCHs and/or from a wider time frame. An additional problem of underreporting of abuse in LTC, often linked to gaps in training,[19] is well documented and similarly observed in our study (e.g., LTCH-005). This issue of underreporting is compounded by the ambiguous wording of the FLTCA 2021, which specifies that only incidents of abuse and neglect that "may constitute a criminal offence" be reported to police. This study relies on publicly available inspection reports as an administrative data source. As such, findings are limited by the completeness, accuracy, and consistency of documentation within these reports.

CONCLUSIONS

Despite the FLTCA 2021 requiring Ontario LTC licensees to immediately report alleged, suspected, or witnessed incidents of abuse or neglect that may constitute a criminal offence, documentation of police involvement was infrequently and inconsistently reflected in our sample of 2024 MLTC inspection reports. Our findings suggest that incidents describing potentially criminal conduct were often managed and documented within regulatory frameworks, with limited indication or referral to law enforcement. The persistent underuse of police, even when incidents meet clear legal thresholds for offences, including theft, fraud, assault, or unlawful confinement, contributes to the perpetration and normalization of abuse in LTC. While tensions exist between calling for greater criminal accountability and avoiding an overly policed LTC environment, the failure to uphold mandatory reporting requirements suppresses avenues for accountability and upholds a well-documented cycle of abuse in this sector.

ACKNOWLEDGEMENTS

The authors would like to acknowledge Natalie Malyjasiak, Sharuya Mathavan, Anthoneil Newman, and Zainab Khalid for their diligent contributions to data collection during this research.

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on conflicts of interest disclosure and declare that we have none.

FUNDING

This research did not receive external funding.

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APPENDIX A (part 1 of 2). Required police intervention in LTC per current Ministry of Long-Term Care (MLTCA) legislative and regulatory framework

Fixing Long-Term Care Act, 2021 (Legislation)

Police record checks: 81 (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age.

Regulation: 92 (1) The Lieutenant Governor in Council may make regulations for carrying out the purposes and provisions of this Part.
(k) governing screening measures for the purposes of section 81, including specifying the kinds of police record checks required under subsection 81 (2);
(l) requiring licensees to obtain regular declarations from staff and volunteers, including, and without limiting the generality of the foregoing, requiring declarations about criminal convictions from persons for whom a police record check was required under subsection 81 (2).

Use of force: 151 (4) An inspector named in a warrant issued under this section may use whatever force is necessary to execute the warrant and may call upon a police officer for assistance in executing the warrant.

ONTARIO REGULATION 246/22: Under: Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1

Prevention of abuse and neglect (section 105): Police notification
Police notification: 105. Every licensee of a long-term care home shall ensure that the appropriate police service (*amendment 390 replaced word "force" for "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.

SCREENING MEASURES AND ONGOING DECLARATIONS
Hiring staff, accepting volunteers
252. (1) This section applies where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.
(2) The police record check must be
• conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and
• conducted within 6 months before the staff member is hired or the volunteer is accepted by the licensee.
(3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

(3) When a licensee hires a staff member or accepts a volunteer during a pandemic, the following modifications to the requirements of section 81 of the Act and section 252 of this Regulation apply:
1. Subsection 81 (2) of the Act does not apply.
2. Section 252 applies, despite paragraph 1 and subsection 252 (1), with the following modifications:
   i. subsections 252 (2) and (3) do not apply;
   ii. if a police record check that complied with subsections 252 (2) and (3) was provided to the licensee, subsection 252 (5) applies;
   iii. if a police record check that complied with subsections 252 (2) and (3) was not provided to the licensee, subsection 252 (5) does not apply and paragraph 1 of subsection 252 (4) applies with respect to any charge, order, or conviction or other outcome, regardless of when they occurred.
(4) If a staff member is hired or a volunteer is accepted during a pandemic and no police record check that complies with subsections 252 (2) and (3) was provided to the licensee, the licensee shall ensure that a such police record check is provided to the licensee within 3 months after the staff member was hired or the volunteer was accepted, and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.
(5) If a staff member was hired or a volunteer was accepted during a pandemic before this section came into force and no police record check that complied with subsections 215 (2) and (3) of Ontario Regulation 79/10 (General) made under the former Act was provided to the licensee, the licensee shall ensure that a police record check that complies with subsections 252 (2) and (3) of this Regulation is provided to the licensee within 3 months after this section comes into force and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.
(6) Subsections (4) and (5) do not apply with respect to a person who is no longer a staff member or volunteer at the time the police record check would have been required under those subsections.
Screening measures and declarations for directors and management
256. (1) Every licensee of a long-term care home shall ensure that screening measures are conducted before permitting any person to be a member of the licensee's board of directors, its board of management or committee of management, or other governing structure.
(2) The screening measures shall include police record checks.
(3) The police record check must be
   (a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015; and
   (b) subject to subsection (4), conducted within 6 months before the person becomes a member of the licensee's board of directors, its board of management or committee of management or other governing structure.

APPENDIX A (part 2 of 2). Required police intervention in LTC per current Ministry of Long-Term Care (MLTCA) legislative and regulatory framework

ONTARIO REGULATION 246/22: Under: Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1

(4) Where a person will become a member of the licensee's board of directors, its board of management or committee of management or other governing structure as a result of their election under the Municipal Elections Act, 1996, the person must provide a police record check in accordance with this section that was conducted no earlier than 6 months prior to the date their term of office begins and no later than 1 month after their term of office begins.

(5) The police record check must be a criminal record check referred to in paragraph 1 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a member of the licensee's board of directors, its board of management or committee of management, or other governing structure.

Records

278. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:

3. Where applicable, the results of the staff member's police record check under subsection 81 (2) of the Act.
4. If subsection 81 (4) of the Act applied with respect to a staff member, a record showing that the staff member has not been convicted of an offence prescribed under subsection 255 (1) of this Regulation or found guilty of an act of professional misconduct prescribed under subsection 255 (2).

Volunteer records

279. (1) Every licensee of a long-term care home shall ensure that a record is kept for each volunteer that includes at least the following with respect to the volunteer:

1. Where applicable, the results of the volunteer's police record check under subsection 81 (2) of the Act.

LTC = long-term care.

APPENDIX B. Glossary of definitions of "abuse" and "neglect" from ontario regulations 246/22 under the fixing long-term care act 2021

Part 1: Interpretation
Definitions:
"Abuse"—definition
2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,
"emotional abuse" means,
(a) 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, or
(b) any threatening or intimidating gestures, actions, behaviour, or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour, or remarks understands and appreciates their consequences ("mauvais traitements d'ordre affectif");
"financial abuse" means any misappropriation or misuse of a resident's money or property ("exploitation financière");
"physical abuse" means subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident ("mauvais traitements d'ordre physique");
"sexual abuse" means
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member ("mauvais traitements d'ordre sexuel");
"verbal abuse" means
(a) 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, or
(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences ("mauvais traitements d'ordre verbal").
(2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.
(3) For the purposes of the definition of "sexual abuse" in subsection (1), sexual abuse does not include
(a) touching, behaviour, or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living; or
(b) consensual touching, behaviour, or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member.

"Neglect"—definition
7. 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.

APPENDIX C. Glossary of terms related to LTC reports

Types of inspections[41]:
Critical incident report: *Critical incident reports are summaries of unannounced inspections by a ministry LTCH inspector conducted on the basis of reports made by the LTCH. A critical incident is defined as "an unintended event that occurs when a patient receives treatment that results in death or serious disability, injury, or harm, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment" (ISMP, 2016).*
Proactive compliance inspection: *Proactive compliance inspections are summaries of unannounced inspections by a ministry LTCH inspector conducted to identify any noncompliance with the Fixing Long-Term Care Act (FLTCA) and Ontario Regulation 246/22 using a standardized approach. These are stand-alone inspections and do not cover complaints, critical incidents, follow-ups, or post-occupancy, unless it is necessary.*
Follow-up report: *Follow-up reports are summaries of unannounced inspections by a ministry LTCH inspector conducted on the basis of following up on a previously issued compliance order to ensure that the home has corrected the noncompliance.*
Complaint report: *Complaints are summaries of unannounced inspections by a ministry LTCH inspector conducted on the basis of complaints received by a resident, family member, staff member, or the public.*

Types of penalties[42]:
Written notifications: *May be issued when a noncompliance is identified as low impact or risk to a resident.*
Compliance orders: *Will be issued when a noncompliance is identified as significant impact or risk to a single resident's health, safety, or quality of life, or moderate impact or risk to multiple residents.*
Administrative monetary penalties (AMPs): *An inspector is required to issue an AMP if a licensee:*
- *Has not complied with a compliance order made under the Act; or*
- *Has not complied with a requirement under the Act that results in a compliance order being issued, and the licensee has received at least one other compliance order for noncompliance with the same requirement within a 3-year period.*

The AMP amount is set out in the FLTCA and Ontario Regulation 246/22 based on the nature of the noncompliance and the compliance history.

LTCH = long-term care home.