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: June 4, 2025
Inspection Number: 2025-1007-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Cheltenham Community, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 13 -16, 20, 22, 23, 27 - 30, June 3 and 4, 2025
The inspection occurred offsite on the following date(s): May 27, 2025 and June 2, 2025

The following intake(s) were inspected:
- Intake: #00146487 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the doors leading to non-residential areas were kept locked when they are not being supervised by staff.

An observation revealed that the nursing supply rooms on three floors were not locked, allowing access to the rooms. A subsequent observation revealed the supply room door locks were fixed and locked on May 13, 2025.

Sources: Inspector's observations; and interview with the Executive Director (ED).

Date Remedy Implemented: May 13, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home. On May 9, 2025, the inspector observed the visitor policy was not posted in the home.

The visitor policy was posted in the home some hours later on May 9, 2025.

Sources: Inspector's observations; and interview with the ED and Director of Care (DOC).

Date Remedy Implemented: May 9, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

i) A resident's care plan indicated that they required fall prevention interventions due to risk for falls.

The resident was observed with no fall interventions in place. A Registered Practical Nurse (RPN) acknowledged that the fall prevention interventions were not provided as specified in the resident's plan of care.

Sources: Inspector's observation, review of the resident's clinical records, and interviews with a Personal Support Worker (PSW) and RPN .

ii) A resident's care plan indicated they used a specific device for ambulation, and that staff were required to monitor the resident as they tended to ambulate without the device.

The resident was observed in the common area ambulating without the device present. A RPN stated that the resident required the use of the indicated device and that it was not provided as specified in the resident's plan of care.

Sources: Inspector's observation, review of the resident's clinical records, and interviews with the PSW and RPN.

b) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident's care plan stated that staff were to provide a specific level of assistance with meals.

The resident was observed during meal time, and staff did not provide the required assistance to them as specified in their plan of care.

Sources: Inspector's observation, review of the resident's clinical records, and

interview with the PSW.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

On an identified date, Point of Care (POC) documentation indicated that a resident consumed a specific amount of their meal. However, the inspector observed that the resident consumed less than that amount.

A PSW who assisted the resident with their meal, acknowledged that the documentation was incorrect.

Sources: Inspector's observation of a meal service, review of the resident's POC documentation, and interviews with the PSW, DOC and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed, and the care set out in the plan was no longer necessary.

A resident's care plan indicated that they should receive a special item during the snack service, however an observation revealed it was not provided to them. A PSW reported that they did not provide the item to the resident due to a change in their condition. A RPN acknowledged that the plan of care was not revised and updated when the resident's needs changed.

Sources: Inspector's observation, review of the resident's care plan, and interviews with the PSW and RPN.

WRITTEN NOTIFICATION: Air Temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 1.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.

The licensee has failed to ensure that the temperature was measured and documented in writing, in at least two resident bedrooms in different parts of the home for a specific time period.

Sources: Inspector's observation, and interview with the Director of Environmental Services.

WRITTEN NOTIFICATION: Air Temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperatures required to be measured, in at least two resident bedrooms in the home, was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, on multiple dates for a specific time period.

Sources: Inspector's observation , and interview with the Director of Environmental Services.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record related to the annual evaluation of the pain management and skin and wound program that occurred on March 31, 2025, included the dates that the summary of changes were implemented.

Sources: The home's annual pain management program evaluation, the home's annual skin and wound program evaluation, and interviews with the DOC and ADOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member

of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident's skin condition was assessed by a Registered Dietitian (RD) when it worsened.

The RD did not assess a resident until two months after the initial identification of a wound. The DOC acknowledged that no referral was sent to the RD for assessment.

Sources: Review of the resident's clinical health records, the home's policy titled "Referral to Dietitian and/or Director of Dietary Services," and interviews with the RD, RN and DOC.

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident was monitored for the effectiveness of the pain medication administered.

In accordance with O. Reg 246/22, s.11. (1) b, the licensee is required to ensure that written policies developed for the pain management program were complied

with. Specifically, the home's Pain and Symptom Management Policy directed staff to monitor and evaluate the effectiveness of pain medications in relieving resident's pain using the pain scale in the vitals section of the electronic documentation system.

A review of the resident's clinical health records showed that staff did not complete follow-up pain assessments on multiple occasions when the resident experienced pain and received scheduled medication.

Sources: Review of the resident's clinical health records, the home's policy titled "Pain and Symptom Management," and interview with the ADOC.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the nutritional programs included the development and implementation of policies and procedures relating to nutritional care.

In accordance with O Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that

written policies and procedures for monitoring food temperatures were complied with.

Specifically, the staff did not comply with the home's policy titled "Food Temperature Recordings", which indicated that staff were to take the holding temperature of foods just before serving to ensure safety.

A meal service was observed on an identified date. The point of service food temperature record was reviewed, and it did not contain the temperature recording for three items for the meal service. Further review identified several meals, from a specific time period, where temperatures were not recorded prior to meal service.

Sources: Inspector's observation of meal service, review of the point of service food temperature records, homes' policy titled, "Food Temperature Recording", and interview with the Director of Dietary Services (DDS).

WRITTEN NOTIFICATION: Menu Planning

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the planned dessert menu was offered to a resident.

During a meal observation, staff did not offer a resident any dessert prior to assisting them out of the dining room.

Sources: Inspector's observation, review of written menu, and interview with the PSW.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Sufficient time for every resident to eat at their own pace.

The licensee has failed to ensure that staff provided a resident with sufficient time to eat.

A PSW was observed feeding a resident their meal in a short timeframe. As a result, the resident was not given time to eat their main entrée or dessert before being exited from the dining room.

Sources: Inspector's observation, and interview with a PSW.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service

s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required feeding assistance was not served a meal until someone was available to provide assistance to the resident.

During the meal service, a resident who required feeding assistance was serve their food without any staff available to assist them for a period of time. A PSW acknowledged that they were not supposed to serve food to the resident when there was no staff to assist them with feeding.

Sources: Inspector's observation, review of the resident's clinical records, and interviews with the PSW, DDS and DOC.

WRITTEN NOTIFICATION: Housekeeping

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that cleaning and disinfection of shared resident care equipment was performed by staff after use.

In accordance with O. Reg 246/22, s.11. (1) b, the licensee is required to ensure that written policies developed for the Infection Prevention and Control (IPAC) program were complied with. Specifically, the home's Equipment Cleaning - Resident Care & Medical Policy instructed staff that all shared equipment, including lifts, must be cleaned and disinfected after each use by team members using the item. Furthermore, lifts were to be disinfected between each resident use.

Two PSW staff were observed using a mechanical lift to transfer a resident. The mechanical lift was not disinfected after use.

Sources: Inspector's observation, the home's policy "Equipment Cleaning - Resident & Medical", and interviews with the PSW and IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 10.4 (h) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that residents were provided assistance to perform hand hygiene before meals.

During an observation of a meal service, multiple residents were observed entering the dining room and they were not offered or assisted with hand hygiene before their meal.

Sources: Inspector's observation, review of LTCH's Hand Hygiene Policy, IPAC Standard for Long Term Care Homes, revised September 2023, and interviews with the PSW and DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that after a confirmed enteric outbreak was declared on a specified date, symptoms were appropriately recorded for all symptomatic residents on the outbreak line list, including two residents.

Sources: Review of two resident's progress notes and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Medication Management System

NC #018 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 they complied with written policies and protocols that were developed for the medication management system to ensure the medication storage audits were completed.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee is required to ensure that written policies and protocols developed for the medication management system were complied with. Specifically, staff did not comply with the policy “Risk Management Plan” which required the medication storage areas to be audited monthly.

The monthly medication storage audits were not completed for a specific time period, as confirmed by the DOC. As a result, medications that had been discontinued for four residents and left in the fridge were not identified for removal.

Sources: Inspector's observation of a medication room, review of LTCH policy” Risk Management Plan- Nursing" and interview with the DOC.

WRITTEN NOTIFICATION: Medication Management System

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
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.

The licensee has failed to ensure that their written policy related to medication management was complied with.

Specifically, a RPN did not implement the home's policy titled "Medication Administration and Documentation: The Medication Pass", The policy stated that during medication administration, staff should document on the MAR for each medication administered.

A RPN did not document the administration of multiple residents medications in the MAR. The RPN acknowledged that all residents received their medications, but they failed to document the administration.

Sources: Review of MAR for residents, review of LTCH policy " Medication Administration and Documentation: The Medication pass, and interviews with the RPN and DOC.

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure that only drugs and drug-related supplies were stored in the medication cart.

A medication cart was observed to have items that were not drugs or drug-related supplies. The DOC acknowledged that these items should not be stored in the medication cart.

Sources: Inspector's observation, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1) (d) (i)
Drug destruction and disposal
s. 148 (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,

The licensee has failed to comply with the home's policy for discontinued medications, as included in the home's medication management system.

In accordance with O. Reg.246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols for drug destruction and disposal developed for the medication management system were complied with.

The registered staff did not comply with the policy “Medication Destruction and Disposal – non narcotic/controlled medications” which required discontinued medications to be removed from the medication storage area following a prescriber’s order to discontinue the medication of the resident.

The inspector observed discontinued medications for four residents in a medication room refrigerator.

The DOC acknowledged that the medications were discontinued for the residents and should have been removed from the medication refrigerator.

Sources: Inspector's observation, review of four residents clinical records, review of CareRx's policy "Medication Destruction and Disposal (non-Narcotic/Controlled medications)", and interview with the DOC.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1) (d) (ii)
Drug destruction and disposal
s. 148 (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home

that provides for the ongoing identification, destruction and disposal of,
(d) a resident's drugs where,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician.

The licensee has failed to comply with the home's policy for discontinued medication, as included in the home's medication management system.

In accordance with O. Reg.246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols for drug destruction and disposal developed for the medication management system were complied with.

The registered staff did not comply with the policy "Medication Destruction and Disposal – non narcotic/controlled medications" which required discontinued medications to be removed from the medication storage area following a prescriber's order to discontinue the medication and/or following the discharge or death of a resident.

The inspector observed discontinued medication for a resident in the medication room refrigerator, though the resident passed away and was discharged from the home previously.

The DOC acknowledged that the medication were discontinued for the resident and should have been removed from the medication refrigerator.

Sources: Inspector's observation of the medication room, review of the resident's clinical record, review of CareRx's policy "Medication Destruction and Disposal (non-Narcotic/Controlled medications)", and interview with the DOC.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to comply with the home's policy for the destruction of non-controlled substances, as included in the home's medication management system.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols for drug destruction and disposal developed for the medication management system were complied with.

Registered staff did not comply with the policy "Medication-LTC-Narcotic and controlled drugs management" which required all drugs designated for disposal to be placed in the designated container provided by the medical waste company.

The inspector observed non-controlled medications for disposal and destruction in a medication room. There were two white buckets on the floor. A large clear plastic bag which included medication blister packs and medication pouches for a resident were lying on top of the buckets with various medications still inside the packages. The medications were not securely stored in the designated container as per the home's policy.

The DOC acknowledged that when medications were to be disposed, staff were

expected to place the medications in the designated container to ensure it's security, and that the staff did not follow the home's process for drug destruction and disposal.

Sources: Inspector's observation of a medication room, review of CareRx's policy "Medication Destruction and Disposal (non-Narcotic/Controlled medications)", and interview with the DOC.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
3. The home's Medical Director.

The licensee has failed to ensure that the home's Medical Director (MD) was a member of the Continuous Quality Improvement (CQI) Committee. A review of three CQI meeting records showed that the MD was not present.

Sources: Review of CQI Committee meeting minutes; and interview with the ED.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the home's registered dietitian (RD) was a member of the CQI Committee. A review of three CQI meeting records showed that RD was not present.

Sources: Review of CQI Committee meeting minutes; and interview with the ED.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that a pharmacist from the pharmacy service provider was a member of the CQI committee. A review of three CQI meeting records showed that the pharmacist was not present.

Sources: Review of CQI Committee meeting minutes; interviews with the ED and Pharmacist

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the CQI committee was composed of an employee of the licensee who was a member of the regular nursing staff of the home.

Sources: Review of CQI Committee meeting minutes; and interview with the ED.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the CQI committee was composed of at least one employee of the licensee who was hired as a PSW or provided personal support services at the home and met the qualification of PSWs.

Sources: Review of CQI Committee meeting minutes; and interview with the ED.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the CQI committee was composed of at least one member of the home's Residents' Council.

Sources: Review of CQI Committee meeting minutes; and interview with the ED.

COMPLIANCE ORDER CO #001 Air Temperature

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

1) Develop and implement a written process that identifies the immediate action(s) to be taken when the air temperature of the home is below 22 degrees Celsius (°C).
2) The process developed must include the following requirements:
- documentation of the action(s) taken to resolve the lower temperatures
- the name of the person who completed the action(s)
- the outcome of the action(s) taken
3) Retain all records until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied with.

Grounds

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 °C.

A review of the home's air temperature logs for a specific time period, revealed that on multiple dates, the air temperatures fell below 22 °C in resident bedrooms and common areas. The air temperature fell as low as 16.0 °C and no actions were taken to remedy the lower temperatures on multiple dates.

Sources: Review of the home's air temperature logs and interview with the Director of Environmental Services.

This order must be complied with by July 18, 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.