Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 19, 2026
Inspection Number: 2026-1088-0001
Inspection Type: Proactive Compliance Inspection
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Peterborough, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22-23, 26-30, 2026, and February 2-6, 9-13, 17-19, 2026.
The inspection occurred offsite on the following date(s): February 12, 2026

The following intake(s) were inspected:
Intake: #00166538 - Proactive Compliance Inspection

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

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

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. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times.

A resident indicated they were unable to ‘press their call bell’ due to changes in their health status. Resident indicated they could not use their call bell. The resident’s call bell was not within the resident’s reach.

Sources: observations; and an interview with the resident.

Remedied date: February 12, 2026

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

The resident's clinical records indicated Palliative care/comfort care however did not indicate what interventions were implemented. Record review indicated the care plan included one intervention which indicated to provide emotional support. The Pain/Palliative Lead confirmed the resident’s care plan should include other interventions for staff to implement when the focus of the care plan was Palliative care.

Sources: Palliative Care policy, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Record review of the resident's care plan indicated the resident was to be repositioned every one to two hours to prevent bed rest complications. The Director of Care (DOC) confirmed the intervention had not been assigned to the kardex which the Personal Support Workers (PSWs) referenced for resident care interventions.

Sources: resident's clinical records; and an interview with staff.

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 resident's care plan indicated they required turning and repositioning every two hours. The DOC confirmed there was no assigned task in electronic documentation record for the resident to be turned and repositioning every two hours and therefore there was no documentation by the PSW's indicating the provision of care was provided.

Sources: Extendicare Documentation Guide, the resident's clinical records; and an interview with staff.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair.

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary.

Resident rooms, and resident common areas within the home were observed unclean, specifically flooring, windows, window screens and heating/cooling units were observed visibly soiled.

Sources: observations.

WRITTEN NOTIFICATION: Duty to respond

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Resident Council and Food Committee meeting minutes were reviewed. Documentation failed to identify that complaints, concerns and/or recommendations brought forth from the Resident Council and Food Committee members were responded to within 10 days. Documentation identified that many of the concerns voiced by Resident Council and Food Committee remain outstanding.

Sources: Resident Council and Food Committee meeting minutes; and an interview with members of the Resident Council.

WRITTEN NOTIFICATION: Doors in a home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
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.

1.Identified non-residential room doors were observed propped open during the inspection. Staff were not observed in attendance in the rooms and or the adjacent

hallway during observations. The identified rooms were equipped with locking mechanisms but were not being utilized.

Sources: observations.

2. A door leading to a non-residential hallway was observed unsecured and unlocked during the inspection. The door leading to the non-residential hallway was not equipped with a locking mechanism to restrict entry to residents. Staff were not observed in the service hallway during dates identified.

Sources: observations.

WRITTEN NOTIFICATION: Elevator

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 13
Elevators
s. 13. Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

A double-sided elevator was observed in use within the long-term care home, the elevator is accessible for use by residents, staff and others. The rear door of the elevator was observed opening into a non-residential area; the rear elevator door is not equipped with a mechanism to limit access to non-residential areas.

An elevator which is not equipped with a mechanism to restrict access to non-residential areas poses risk of harm to residents.

Sources: observations; and interviews with managers.

WRITTEN NOTIFICATION: Privacy curtains

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The privacy curtains in identified shared resident rooms did not fully enclose the resident's bedspace to allow for privacy.

Sources: observations.

WRITTEN NOTIFICATION: Windows

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

Windows, in identified resident common areas, were observed without screens.

Sources: observations.

WRITTEN NOTIFICATION: General requirements

NC #011 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.

1. The skin and wound care program annual evaluation's was incomplete and did not include the date the changes were implemented.

Sources: Quality program evaluation skin care; and an interview with staff.

2. The annual pain management program evaluation did not include a summary of the

of the changes made and the dates that those changes were implemented.

Sources: Quality program evaluation-Palliative Care and Pain Management; and an interview with staff.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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 home's nursing and personal support services annual evaluation was incomplete and did not include the date the changes were implemented.

Sources: Quality Program Evaluation nursing and PSW staffing services; and an interview with staff.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items.

Personal care items were observed unlabeled in shared resident rooms/washrooms.

Sources: observations.

WRITTEN NOTIFICATION: Skin and wound

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A resident returned home from hospital, the registered staff did not document using the home's clinically appropriate instrument designed specifically for wound assessments when the resident was assessed as having altered skin integrity.

Sources: the resident's clinical records; and an interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #015 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 (RD) who is a member of the staff of the home, and that any changes the RD 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 resident's clinical records indicated the resident had altered skin integrity and their wound was slow to heal. The registered staff indicated a referral would be made to the Registered Dietitian (RD). Record review of the resident's clinical records indicated that a RD referral was not made until twelve days later at which time the RD assessed the resident.

Sources: the resident's clinical records; and an interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 56 (2) (d)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time.

A resident was assessed as requiring the assistance of staff and the use of a mechanical device for identified care needs. Documentation identified interventions were in place related to continence care for the resident. The resident indicated they had a negative outcome to their care due to delays in staff response to their continence care needs.

A call bell audit report, specific to the resident, was reviewed. Documentation identified numerous dates and times when the staff response to call bells were delayed.

Sources: resident staff communication and response report; and an interview with a resident.

WRITTEN NOTIFICATION: Pain management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The resident's e-Mar indicated that they were given PRN pain medication on several occasions for pain management. The registered staff were to complete a pain assessment after administering a PRN medication. There were missed pain assessment's using the clinically appropriate assessment instrument when the registered staff administered a PRN analgesic to the resident.

Sources: the residents clinical records; and an interview with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration

programs

NC #018 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.

1.The licensee's policy directs that dietary staff are to sanitize the thermometer probe before inserting it into the next menu item, and also when finished taking food temperatures.

A dietary staff was observed taking and recording food temperatures, for planned menu items. The dietary staff was observed inserting the temperature probe into one menu item, taking the temperature, removing the probe from the menu item and then wiping the probe on a dish cloth, before inserting the probe into the next menu item(s). The dietary staff was not observed sanitizing the temperature probe between menu items.

Sources: observations; licensee policy; and an interview with a manager.

2. The licensee's policy directs that dietary staff are to cover food in the steam table during hot food holding with the appropriate lids to minimize the effects of heat loss.

A dietary staff was observed entering the servery, removing all the lids that were covering hot menu items being held within the steam table, and exiting the servery with the lids, prior to meal service.

A dietary manager indicated that such actions would affect food temperatures.

Sources: observations; licensee policies; and an interview with a manager.

WRITTEN NOTIFICATION: Food production

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 78 (3) (b)
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system

are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

A dietary staff was observed using their bare hands/fingers to plate menu items.

Source: observations.

WRITTEN NOTIFICATION: Food Production

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 78 (6) (b)
s. 78 (6) The licensee shall ensure that the home has, (b) institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures.

1. Plated hot foods were observed covered with foil, and placed on plastic trays, for those residents assessed as requiring tray service. The prepared trays sat on an unheated severy ledge, for long periods of time, before staff transported the food trays to resident rooms.

A dietary staff indicated there was not enough thermal covers to hold and/or transport hot foods for those assessed as requiring tray service.

Sources: observations; and interviews with staff and a manager.

2. A dining service observation identified delays in a meal service, specifically residents seated at tables waiting for their main entrée to be served.

A dietary staff indicated that the meal service was delayed as they did not have the appropriate number of an identified equipment item to prepare menu items. The dietary staff indicated they had been without the required equipment for months. The dietary staff indicated meal service is impacted without the required equipment to prepare/plate the meal.

Sources: observations; and an interview with a dietary staff.

3. A manager indicated being aware that food temperatures had been identified as a

concern in the home. The manager indicated that a contributing factor to foods not being maintained at a safe temperature could possibly be related to the heat control settings, on the temperature dials, of the steamtables not being visible. The manager indicated that the actual number that indicates the temperature of the steam table wells have been 'rubbed off' from wear, and staff would not be able to determine the appropriate setting for holding foods.

Sources: observations; and an interview with a manager.

WRITTEN NOTIFICATION: Dining and snack service

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 79 (1) 7
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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During a dining observation, identified residents were observed being served their desserts prior to finishing their main entrée.

Source: observation.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #022 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).

1. The Environmental Service Manager (ESM) confirmed that enhanced cleaning of high touch surfaces with a one minute contact was not completed in all homes areas when the third floor was in a respiratory outbreak. The Infection Prevention and Control (IPAC) lead confirmed that the housekeeping staff should be cleaning all high touch

surface in the all resident rooms and home areas with a one minute contact.

Sources: The home's Housekeeping /janitorial chemical actions and contact times, High touch point areas checklist; and an interview with staff.

2. The housekeeping staff was to clean high touch surfaces using a disinfectant twice a day during a outbreak. Inspector observed a housekeeping staff cleaning the high touch surfaces in a resident room. The housekeeper reported that they did not clean two high touch surfaces in the resident's room and confirmed these were high touch surface.

Sources: observation: high touch point areas checklist, the home's policy-Cleaning Frequency; and an interview with staff.

3. Observation in the dining room indicated three residents were not supported by staff to perform hand hygiene prior to meal service.

Sources: observations; the home's policy Infection Prevention-Resident Hand Hygiene Procedure; and an interview staff.

4. Droplet contact precaution signage was observed to be incorrectly placed for three resident rooms. The IPAC lead confirmed the droplet precautions signs posted on two resident rooms were posted incorrectly. The Director of Care Quality was aware of the inspector's observation of the droplet contact sign for a different room and confirmed the posted sign was corrected the day of the observation.

Sources: Line list, observation resident of rooms, Public Health outbreak checklist; and interview with staff.

WRITTEN NOTIFICATION: Infection preventions and control program

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The IPAC lead confirmed that two of the resident's clinical records were missing documentation related to symptom monitoring, when the residents had respiratory symptoms.

Sources: Line list, Infection surveillance- manual documentation, two resident clinical records; and interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: O. Reg 246/22, s. 123 (2)

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.

1.The licensee's policy directs that registered nursing staff are to record the temperatures of the medication fridge at minimum of twice a day. The temperature logs were reviewed, for medication refrigerators on the identified resident home areas (RHAs). The documents failed to identify that the temperature of the medication refrigerators were being taken twice daily.

Sources: observations; refrigeration temperature logs, and the licensee policy.

2. The licensee's policy directs that, two nurses, one from the outgoing shift, and one from the incoming shift, will count and sign-off on the Narcotic and Controlled Substances Count sheets every shift change.

The controlled substance medication shift counts sheets were reviewed for identified RHAs. Documentation failed to identify that shift-to-shift controlled substance counts were being consistently documented as being completed by the oncoming nurse.

Sources: controlled substance medication shift count sheets, and licensee policy.

3. The licensee's policy directs that, all controlled substance medication waste will be witnessed by two nurses.

The controlled substance medication surplus record forms were reviewed. Documentation failed to identify that all controlled medication waste was being consistently witnessed by two nurses.

Sources: controlled substance medication surplus records, licensee policies; and an interview with a manager.

4.The licensee's policy directs that, staff are to dispose of all surplus insulin with a witness present.

The medication destruction sheets were reviewed. Documentation failed to identify that the disposal of insulin was being witnessed by a second registered nursing staff.

Sources: medication destruction sheets, licensee policy; and an interview with a manager.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg 246/22, s. 148 (4) 8

Drug destruction and disposal

s. 148 (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons

referred to in clause (3) (a) shall document the following in the drug record: 8. The manner of destruction of the drug. O. Reg. 246/22, s. 148 (4).

The controlled substance medication surplus records were reviewed. Documentation failed to identify the manner in which medications were destroyed.

Sources: controlled substance medication surplus records; and an interview with a manager.

COMPLIANCE ORDER CO #001 Air temperature

NC #026 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 must ensure:

1.Take immediate measures to ensure the home is being maintained at a minimum temperature of 22 degrees Celsius (°C).

2. Develop and implement a plan to ensure the home is being maintained at a minimum temperature of 22°C . The plan should include actions to be taken if temperatures within the home are identified to be below 22°C, and measures to ensure resident comfort. The plan must be documented and include those who participated in the development and implementation of the plan. All documentation must be retained.

3. Develop and implement a plan to ensure staff who access resident rooms, dining rooms, lounges and activities rooms are aware of the importance of the PTAC (heating and cooling) units in maintaining resident comfort. The plan should include the importance of leaving units turned on, required temperature settings, and communicating of any concerns with PTAC units to maintenance staff. The plan must

be documented and include those who participated in the development and implementation of the plan. All documentation must be retained.

4. Plans are to be communicated to all staff. The communication must be retained.

Grounds:

Temperature Monitoring Log(s) were reviewed. Documentation identified that the air temperature within the home was not being maintained at a minimum temperature of 22 degrees Celsius (°C). Documentation failed to identify that corrective action had been taken when air temperatures were taken and recorded as being below 22 °C.

Resident Council and Food Committee meeting minutes identified residents had voiced concerns, on several occasions, indicating the home was ‘cold’.

Failure to ensure the home is maintained at a minimum temperature of 22 °C poses risk to residents, specifically their comfort.

Sources: observations; temperature logs, Resident Council and Food Committee meeting minutes; and interviews with residents, staff and managers.

This order must be complied with by May 14, 2026.

COMPLIANCE ORDER CO #002 Dining and snack service

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

The licensee must ensure:

1. All Dietary Staff that have been assigned, scheduled or worked on an identified resident home area, during identified dates, are to be retrained on the licensee's policy related to holding and food distribution, and food temperatures. Documentation of re-training of dietary staff are to be retained, including staff names, role, and date of re-training.

2. Policies related to food temperatures and, holding and food distribution are to be re-communicated to all dietary staff. Communication, including date of communication and method of communication must be retained.

3. Repair or Replace the Thermostat/Dial Labels on steamtables in the identified resident home areas as per the manufacturer's instructions. Retain invoices related to steamtable repair service.

4. Maintenance services and/or a qualified technician to verify and confirm that the thermostat on the steam table in an identified resident home area is in good working order to hold hot foods at the safe hot-holding temperatures. Verification of functionality must be retained.

Grounds:

1. Milk and lactose free milk were observed sitting at room temperature on carts, during dining and snack service. A manager indicated that all milk, creamer and lactose free milk are to be kept in thermal cooling bins when they are not in the refrigerator.

Sources: observations; and an interview with a manager.

2. A staff was observed preparing and plating menu items for two residents assessed as requiring tray service. Hot food menu items, requested for the residents, were plated, covered with foiled and placed on a servery ledge. Tray #1, for a resident, sat on the ledge for 10 minutes prior to the food tray leaving the dining room for delivery to the resident; tray #2, for another resident, sat on the ledge for 8 minutes prior to staff leaving the dining room with the food tray for delivery to another resident. There was no observed heating source to keep the prepared trays warm prior to service to residents.

Source: observations.

3. Food Temperature records were reviewed for an identified resident home area. Documentation identified, dates and times, where foods, both hot and cold, were not held or served at safe temperatures.

Documentation identified several dates in which cold food temperatures were recorded to be above 4 degrees Celsius (°C); and hot food temperatures below recorded as being below 60 °C.

Resident Council and Food Committee meetings minutes identified residents have voiced several concerns about the temperature of foods.

Sources: Temperature Reports, Resident Council and Food Committee meeting minutes; and interviews with residents, and a manager.

This order must be complied with by May 14, 2026.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
The licensee has been previously issued non-compliance pursuant to O. Reg. 246/22, s. 79 (1) 5, specifically issued a Compliance Order, under inspection, 2023-1088-0001, which was issued on August 9, 2023

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Pain Management Program

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

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

The licensee must ensure:

1.The interdisciplinary team will meet and review and revise a resident care plan related to pain management. Keep a documented record of the dates and names of the interdisciplinary team who reviewed the care plan and interventions implemented.

2. Provide education to three Registered Practical Nurse's on when and how to update a resident’s care plan related to pain management. Keep a documented record of the education content, who provided the education, and the date and signature of who was educated.

Grounds:

1. The resident's individualized plan of care for pain management was not developed

and implemented with non-pharmacological interventions based on the resident's pain assessments. Several of the resident's pain assessments indicated the resident had pain. The Pain/Palliative Lead and Registered Practical Nurse (RPN) acknowledged that interventions to manage the resident's pain would be documented in the resident's care plan. Two RPN's indicated they did not know if the resident had a care plan for pain management. Review of the resident care plan indicated the resident had no plan of care for pain management that indicated non-pharmacological interventions to better manage the resident's pain. The Pain/Palliative Lead confirmed that the resident did not have a care plan that included a focus on pain, goals, and interventions to manage the resident's pain including non-pharmacological interventions. When the resident did not have an individualized care plan in place to manage the resident's pain including non-pharmacological interventions it impacted the residents' activities of daily living and emotional wellbeing.

Sources: The homes' Pain Management policy, the resident's clinical records, interview with staff,

2. The individualized plan of care for pain management was not developed and implemented with non-pharmacological interventions based on the resident's pain assessments. Several of the pain assessments indicated the resident had limb pain, which affected their emotional well being. Two of the clinical records indicated some non-pharmacological interventions to manage the resident's pain however were not implemented into the care plan as interventions. A RPN and the Pain/Palliative lead confirmed that a resident's care plan for pain would include non-pharmacological interventions to manage a resident's pain. The Palliative/Pain Lead confirmed there was no pain focus in the resident's care plan, with goals and pain interventions. When there was no care plan developed and implemented with non-pharmacological interventions to manage the resident's pain this impacted the resident's emotional and physical well-being.

Sources: licensee's policy, the resident's clinical records; and interview with staff.

This order must be complied with by May 14, 2026.

COMPLIANCE ORDER CO #004 Specific duties re cleanliness and repair

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

The licensee must ensure:

1. Repair and/or replace walls, ceiling tiles, flooring, windows, leaking plumbing fixtures and equipment within the identified rooms.

2. Conduct an audit of all resident rooms and resident common areas and make a list of repairs to walls, ceiling tiles, flooring, windows and equipment. The audit must be documented.

3. Develop and implement at plan to ensure that all staff are aware of the policy or plan in place to report maintenance concerns via the licensee's software platform. The plan must be documented, including date and participants. The plan must be retained for review by the Inspector.

4.Communicate the plan to all staff. The communication must be dated and include the platform of communication. A documented record of the communication must be retained for review by Inspector.

5.Develop and implement a plan and schedule to ensure that preventative maintenance, specifically repair of walls, ceiling tiles, flooring, windows and equipment, throughout the home is being addressed. The plan should include:
- a review and recommunication of licensee policies related to maintenance services;
- the identification of maintenance concerns within the home, assessment and prioritizing repair or replacement, action taken and resolution;
- oversight by the licensee;
- documentation of the plan including date and participants;
- the plan must be retained for review by the Inspector.

Grounds:

Resident rooms, and resident common areas were observed in a state of disrepair, the disrepair was observed to walls, flooring, ceiling, areas surrounding windows, window screens, bathing equipment and to plumbing fixtures.

A software system used by the licensee, which allows staff to report maintenance concerns within the home was reviewed. Documentation failed to identify the disrepair that was identified during the inspection.

Sources: observations; maintenance logs; and interviews staff and managers.

This order must be complied with by May 14, 2026.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
The licensee has been previously issued non-compliance pursuant to FLTCA, 2021, s. 19 (2) (c), specifically issued a Compliance Order, under inspection, 2023-1088-0001, which was issued on August 9, 2023.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.

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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.

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