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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: March 3, 2026
Inspection Number: 2026-1018-0002
Inspection Type: Proactive Compliance Inspection
Licensee: ATK Care Inc.
Long Term Care Home and City: The Fordwich Village Nursing Home, Fordwich

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10 -13, 17, 19, 20, 23 - 27, March 03, 2026
The inspection occurred offsite on the following date(s): February 18, 25, 2026

The following intake(s) were inspected:
- Intake: #00169748 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 3.
Training
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the

regulations:
3. Behaviour management.

A staff member did not receive training related to Responsive Behaviours Management.

Sources: Interview with the staff and review of their training records.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A resident's care plan had identified responsive behaviours focuses in relation to multiple potential areas. However, their plan of care did not identify potential behavioural triggers and interventions.

Sources: Observation and medical record review of the resident, interview with Registered staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The responsive behaviours program was not integrated in the management of two residents' responsive behaviours.

Sources: Review of the residents' clinical records, review of Dementia Care & Behavioural Supports Policy, interview with the residents and staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (b)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The Responsive Behaviour Program was not, at least annually, evaluated and updated in accordance with evidence-based and/or prevailing practices.

Source: Review of records and communication with the home's administrator.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 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;

A) The home did not comply with their policy on the management of unplanned weight changes for multiple residents; including re-weighing the residents when a significant weight change was identified as well as referral to and assessment by the home's Registered Dietitian (RD) and an interdisciplinary team.

Sources: The residents' clinical health records, interviews with the home's RD, the home's interim Director of Care (DOC), and review of the home's Weight Management policy and procedure.

B) The home did not comply with their policy on hydration monitoring and assessment when they did not assess a resident with decreased fluid intake using the recommended assessment tool. In addition, a Dietary Referral and a Hydration Monitoring Audit were not completed.

Sources: Review the home's Hydration Monitoring and Hydration Assessment Policy and Procedure, a resident's clinical health records, and interviews with the home's interim DOC and other staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (ii)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(ii) body mass index and height upon admission and annually thereafter.

A height was not measured and recorded for six residents between 2025 and 2026.

Sources: Height history data for six residents.

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c) (iii)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,

(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The home's current menu was not approved for nutritional adequacy by a registered dietitian (RD) by considering Dietary Reference Intakes (DRIs) relevant to the resident population.

Sources: the home's spring summer menu approval tool, and interviews with the home's RD and Food and Nutrition Manager.

WRITTEN NOTIFICATION: Food production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

The home's production sheet did not include documentation of three menu substitutions on a specific day.

Sources: The home's production sheets, interview with the home's Food and Nutrition Manager, and observations.

WRITTEN NOTIFICATION: Food production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
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 staff member did not use gloves or tongs to place a food item on plates before it was served to the residents.

Sources: observation and interview with Food and Nutrition Manager.

WRITTEN NOTIFICATION: Food production

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (5) (b)
Food production
s. 78 (5) If any food or beverages are prepared in the long-term care home for persons who are not residents of the home, the licensee shall maintain, and keep for at least seven years, records that specify for each week,
(b) the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home, including revenue and internal recoveries made from cafeteria sales and catering. O. Reg. 246/22, s. 78 (5).

The home regularly offered leftover foods prepared for residents to staff, for staff consumption. The home did not maintain records or charge the staff for these food items.

Sources: observations, interview with Food and Nutrition Manager, and email communications.

WRITTEN NOTIFICATION: Dining and snack service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 home did not comply with their food production policy related to documenting food temperatures when they did not record the temperature of multiple texture modified options served to the residents.

Sources: observations, the home's production sheets, the home's food production policy and procedure, and interview with Food and Nutrition Manager.

COMPLIANCE ORDER CO #001 Duty to protect

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee shall:

A) Ensure an interdisciplinary team assessment is completed for a specific resident related to nutrition, swallowing, and hydration. This shall include, at minimum: a swallowing assessment by a Registered Dietitian and/or Speech Language Pathologist, a review and if required, revision, of the resident's fluid, eating and nutrition care plan, correction of all discrepancies between nutrition-related plan of care documents, and documentation of the assessment(s), resident input, substitute decision maker input (as required), and plan of care revisions in the resident's clinical health records. Include documentation of the date(s) all assessments were completed, and the name of the individual who completed the assessments.

B) Update the home's food production sheets to include how much food kitchen staff should produce at each meal and snack. Ensure the food production sheets include food portions and choices for all residents requiring texture modifications and any required menu substitutions (example, alternative options for food allergies and intolerances) at each meal and snack.

C) Provide training to all kitchen staff related to the following, at minimum: the home's process for following therapeutic menus, production sheets, and diet lists. Maintain a record of the training provided, including the date the training was received, the name of the individuals who completed the training, the name of the individual who delivered the training, and the nature of the training (ie. what was reviewed and training format).

D) Provide training to all staff who are responsible for delivering snacks related to the following, at minimum: documentation of meals and snacks in point-of-care following meal and snack service, the home's process for following therapeutic menus and diet lists. Maintain a record of the training provided, including the date the training was received, the name of the individuals who completed the training, the name of the individual who delivered the training, and the nature of the training (ie. what was reviewed and training format).

E) Conduct an audit twice per week for three weeks (a minimum of six audits total) to ensure a specific resident is receiving their food, nutrition, and hydration-related interventions according to their plan of care at each meal and snack (review a total of 3 meals and 3 snacks for each audit). If corrective action is required, include the date and time the corrective action was taken, and what the corrective action was. Maintain copies of all audits on file, including who completed the audit, and the date the audit was completed.

F) Conduct an audit once per week for a total of three weeks, at minimum, to ensure staff are accurately documenting meal and snack intake consistently for a specific resident. Intake documentation should include meal or snack refusals, when appropriate, and should not have any gaps. If corrective action is required, include the date and time the corrective action was taken, and what the corrective action was. Maintain copies of all audits on file, including who completed the audit, and the date the audit was completed.

G) Conduct an audit once per week for a total of three weeks, at minimum, to ensure staff are accurately measuring and recording point of service food temperatures of pureed food items, before they are served to residents in the home. Maintain copies of all audits on file, including who completed the audit, and the date the audit was completed.

Grounds

Staff were not provided with clear direction on what food type, texture, or choices to serve a specific resident to eat, resulting in neglect.

"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 pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident, with a low Body Mass Index (BMI), indicating they were clinically underweight, was noted to have swallowing difficulties.

Staff were instructed to provide texture modified foods by one staff member, but their diet order remained regular texture, with texture modified foods as an option. Several months passed, and the resident continued to have swallowing difficulties, but no swallowing assessment was completed, and the diet order remained the same. Staff reported they provided only texture modified foods with meals, for the residents safety, but had never been instructed to prepare texture modified snacks. The resident reported to the inspector they did not receive a choice of foods with meals due to their swallowing difficulties. During the inspection, the resident was not offered a choice of texture modified foods at meals on two separate occasions. Staff did not produce all of the texture modified options at meals, as indicated on the home's production sheets. Texture modified snacks were also not produced according to the menu. Meal and snack intake were not recorded, or charted as "not applicable" on multiple occasions.

The resident was to receive a specific regular textured snack, in addition to the texture modified snacks, and a specific food item with a meal once daily, according to their care plan. The specific snack was not added to the resident's diet list. Inspector observed these items not offered or provided during the inspection. A staff member reported the snack was probably not safe to provide to the resident due to their swallowing challenges.

Inspector observed texture modified foods not kept within the steam table prior to meal service, and no temperature was taken prior to serving food to the resident. When the resident received the food, they told a staff member one of the food items was difficult for them to swallow. The food was left with the resident in their room with no monitoring.

The resident was also noted to have food allergies and intolerances, but there were no written instructions to staff or recipes available to instruct staff to serve an alternate food choice, when these items were on the menu.

The resident was referred to the home's RD for reduced fluid intake but the resident

and/or their Substitute Decision Maker were not contacted to identify the causes or solutions.

Sources: a resident's clinical health records, inspector observations, meal production sheets, kitchen communication book, master diet sheet for snacks, and interviews with the resident, the home's RD, NM and other staff.

This order must be complied with by April 13, 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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

FLTCA, 2021, s. 24 (1) Duty to protect.

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.