Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: February 12, 2026
Inspection Number: 2026-1216-0001
Inspection Type: Complaint Critical Incident
Licensee: Hardy Terrace LTC Operating Limited
Long Term Care Home and City: Hardy Terrace, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 9-12, 2026.

The following intake(s) were inspected:
Intake: #00165065 - Critical Incident (CI) 2720-000033-25 -Failure/breakdown of major system - Door access control system
Intake: #00166561 - Complaint re: staffing

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

Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

On December 8, 2025, the home experienced a failure of the door access control system with the fire exit door leading to the outside not locking on the secured unit. A CI was not submitted to the Director (2720-000033-25) until December 11, 2025. The home had staff attend to the door 24/7 until it was repaired on January 14, 2026. During this time, the company hired to repair the locking mechanism noted on January 7, 2026, that the Environmental Services Manager had reported that the doors located in the café leading to a fenced in outdoor area were also not functioning properly. The home failed to report to the Director the breakdown of the door access control system with the café doors not locking as confirmed during interview with the Quality Manager.

Sources: interview with Quality Manager, observations of fire door and cafe doors, record review including documentation from door repair company, door safety audits, door and access control policy, and email communication.