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: September 4, 2025
Inspection Number: 2025-1497-0005
Inspection Type: Proactive Compliance Inspection
Licensee: Maxville Manor
Long Term Care Home and City: Maxville Manor, Maxville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 13-15, 18-22, and 25-28, 2025.

The following intake(s) were inspected:
- Intake: #00155018 - Proactive Compliance Inspection (PCI)

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

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

Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

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. 23 (3)
Cooling requirements
s. 23 (3) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 246/22, s. 23 (3).

The licensee has failed to ensure that their heat related illness policy titled " Prevention and Management of hot weather illness" last reviewed on April 2022 has been reviewed on an annual basis.

The home provided an updated policy date review of August 2025, prior to the inspectors concluding their inspection.

Sources: Homes Prevention and Management of Hot weather illness policy last

reviewed August 2025, interview with the DOC.

Date Remedy Implemented: August 28, 2025

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents when sliding bolt latch locks were added to multiple doors leading to the outside of the home, including fire exit doors.

During the inspection, sliding bolt latch lock devices were observed to be in place on the interior side of multiple doors leading to the outside of the home, including three fire exit doors. On two of the observed fire exit doors, the sliding bolt latch locks were observed to be engaged in the locked position; and, would require manual unlocking in the event of a fire.

The local fire department was notified of the identified concern; and the sliding bolt latch locks were subsequently removed.

Sources: Observations of the inspector, interviews with staff including two PSWs.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a window in the home was maintained in a safe condition and in a good state of repair.

Specifically, there was a damaged or missing component on the lower sash of a window in a resident room; and so, the lower sash of the window was not tight-fitting.

Sources: observations of the inspector, and interview with the an Environmental Services staff.

WRITTEN NOTIFICATION: Duty to respond to Residents council

NC #004 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.

The licensee has failed to ensure that when concerns or recommendations were brought forward by residents council, they were responded to in writing within ten

days of receiving the concern.

Upon review of the homes resident council minutes, it was noted that a concern regarding the call bell response system was brought up in the August, 2024, minutes and in the October, 2024, minutes. The issue was still outstanding and there had been no response received by the home. There have been other outstanding issues as identified by the minutes, with action items still outstanding.

During an interview with the executive assistant, they confirmed that the home does not respond to resident councils concerns in writing, and that they bring it up at the next meeting if the answers are available.

Sources: Resident council minutes, interview with an executive assistant.

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
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,
(e) is available in every area accessible by residents;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

During the inspection, residents were observed to have access to vestibules, enclosed spaces that were located between an inner and exterior door, at multiple

fire exits in the long-term care home.

A resident who entered the vestibule at the F Wing fire exit door was unable to exit without assistance. The resident-staff communication and response system could not be activated from inside the vestibule.

Sources: observations of the inspector, and interviews with staff, including the Environmental Services staff and two PSWs.

WRITTEN NOTIFICATION: Cooling requirements-Heat Related Illness

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (2) (e)
Cooling requirements
s. 23 (2) The heat related illness prevention and management plan must, at a minimum,
(e) include a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. O. Reg. 246/22, s. 23 (2); O. Reg. 66/23, s. 3 (1).

The licensee has failed to ensure that their Prevention and Management of Hot Weather Related Illness, last reviewed on August 2025, included a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council.

Sources: Homes Prevention and Management of Hot Weather related illness policy,

last reviewed August 2025, interviews with Registered Nursing staff.

WRITTEN NOTIFICATION: Cooling Requirements-Heat related illness

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (4)
Cooling requirements
s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 246/22, s. 23 (4).

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented every year during the period from May 15 to September 15, on any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located was 26 degrees Celsius or above at any point during the day; and, anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

Specifically, the homes "Prevention and Management of Hot weather illness" last reviewed on August 2025, does not stipulate the time frames required to implement

the policy, nor does it state what to do in the case the weather is to be forecasted over 26 degrees Celsius or above or if the internal air temperatures of the home reaches over 26 degrees or above.

The home measured air temperatures above 26 degrees in several areas of the home on August 22, 23 and 24, 2025 and there was no action identified as to whether the heat related illness plan was implemented as it's not stated in the home prevention and management of hot weather related illness policy.
Sources: Homes Prevention and Management of Hot Weather related illness policy, last reviewed August 2025, Homes Air temperature logs from July 29, 2025-August 26, 2025 and interview with Environmental Services staff.

WRITTEN NOTIFICATION: Required programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
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:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure the Skin and Wound Care Policy was implemented related to the documentation of weekly assessments.

Specifically, staff did not implement the "Skin and Wound Care Program Policy, #SWM-01-01 (last revised 4/11/2024).

According to the policy, the registered nursing staff were required to conduct weekly assessments of pressure wounds greater than Stage 2 and other skin problems requiring advanced wound care, and to document findings in Point Click Care (PCC). They were also required to conduct weekly assessments of wounds less than Stage 2 and other skin integrity problems, and document the evaluation of treatment outcomes in PCC. Weekly assessments were not documented for two specific residents.
Sources: Interview with a nursing staff, reviewed two resident's health care record and "Skin and Wound Care Program Policy, #SWM-01-01, last revised 4/11/2024.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #009 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 "Food Temperature Recordings" policy was implemented.

The "Food Temperature Recordings" policy, Policy #04-04 (last reviewed 02/04/2025), requires that:

-Food temperatures must be taken of all potentially hazardous food items (hot and

cold) at the end of preparation to ensure that the proper temperature had been met.

-Food temperatures must be logged on the daily Cook's Temperatures Log (CTL) located in the production area of the main kitchen. Temperatures are logged for each meal.

The CTL was reviewed for a specific period and it was noted that there were temperatures missing for several items at lunch time and no temperatures were documented for dinner time.

Sources: Record review of the CTL and Food Temperature Recording Policy and interviews with the Dietary staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
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:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to ensure that there was a process for food services workers, and other staff assisting residents, to be aware of the resident's diets, special needs and preferences - more specifically, related to fluid consistencies.

On a specific date in 2025, a beverages pass was observed on a specific unit. It was noted that there was no menu/list available on the cart for the fluid consistency

required for each resident's individual dietary needs. During a discussion with two Personal Support Workers (PSWs), they indicated that the fluid consistencies for residents was not available on the snack cart.

Sources: observation and interviews with two PSWs.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Additional Requirement 9.1 (f) of the Infection Prevention and Control (IPAC) Standard for Long-term Care Homes (April, 2022; revised 2023) was not implemented when a Personal Support Worker did not use the required personal protective equipment (PPE) (a gown) when providing care to a resident who was on contact precautions at the time of the observation.

Sources: observations of the inspector, and interviews with several staff.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
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,
(ii) that is secure and locked,

The licensee has failed to ensure that a medication cart was secure and locked.

On a specific date in 2025, a medication cart on a specific unit was observed to be left unlocked. Beside the medication cart, a resident who was wandering and exhibiting agitation, was observed to be touching the top of the cart. A Registered Nurse (RN) indicated that the medication cart should have been locked.

Sources: Observation and interview with an RN.

WRITTEN NOTIFICATION: Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (f)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(f) cleaning and disinfection practices;

The licensee failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included cleaning and disinfection practices.

In accordance with subsection 82 (1) and 82 (2) of the Fixing Long-term Care Home Act, 2021, all staff were required to receive training in the area of infection prevention and control, including cleaning and disinfection practices, prior to performing their responsibilities.

However, a Personal Support Worker had worked their first shift, assisting in the provision of care to residents in the long-term care home, prior to receiving training - specifically, related to cleaning and disinfection practices required for infection prevention and control.

Sources: relevant training and orientation records; and, interviews with staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, are equipped with an audible door alarm that allows calls to be cancelled only at the point of activation. Step (1) must be completed by the compliance due date.

2) In order to meet the requirement of step (1), identify all doors that are not already equipped with the required alarm through testing; and, equip them. A written record must be kept of the testing including: the date the test was performed and the name of the person who conducted the test. Each door tested must be identified in the written record, with results documented for each door.

3) Where a door leading to an unsecure outside area is found not to be equipped with the required alarm through testing, implement a risk mitigation strategy that will remain in place until the door is so equipped. At a minimum, ensure that, when staff receive a notification related to the opening of an exterior door through the existing resident-staff communication system (staff phones), they do not cancel the call without visiting the point of activation.

Maintain a written record of everything required under this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a

resident, were equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation.

The exterior leading door located in an activity room, and the fire exit door near a resident room were held open by staff during the inspection without triggering an audible alarm at the door itself. In both cases, staff were able to silence a notification received through the long-term care home's communication and response system without visiting the point of activation.

Over the course of the inspection, it was determined that there were multiple different door systems in the home, which functioned differently. A Environmental Services staff, was not sure which doors leading to unsecure areas outside of the home were equipped with an audible door alarm, and which were not.

Sources: observations of the inspector; and interviews with staff, including interviews with two Environmental Services staff, several PSWs and one Registered Nurse.

This order must be complied with by October 14, 2025

COMPLIANCE ORDER CO #002 Bed rails

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance

with prevailing practices, to minimize risk to the resident;

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 bed safety program that will ensure that where bed rails are used, the resident's bed system is evaluated in accordance with the prevailing practices outlined in the Health Canada (HC) Guidance Document: *Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards* (2008) (the HC guidance document).

2) Evaluate all bed systems in the long-term care home, where bed rails are currently used. The evaluation must be conducted in accordance with the HC guidance document. If an entrapment zone fails the prescribed test, steps must be taken to minimize resident risk and to prevent resident entrapment.

3) Ensure that the program required under step (1) includes plans for the reassessment of bed systems, taking into account the effects of aging components (e.g. loosening of rails, softening of mattresses) and bed system modifications. A new bed system that is created whenever a component of a legacy bed system is changed or replaced (e.g. new bed rails or mattress), or when another accessory is added or removed, must be evaluated in accordance with the HC guidance document.

4) Create and maintain a detailed inventory of all bed systems in the long-term care home. All bed system components must be traceable, and information related to each bed system evaluation (such as the condition and position of rails) must be documented, along with results of entrapment zone testing. For further clarification,

the inventory must include identifying information for all bed system components, including: the bed deck, mattress, and rail type. Relevant corrective action must also be noted as required. Information about mattress compatibility must be clearly and permanently marked on the bed.

5) Ensure that the staff responsible for conducting bed system evaluations receive relevant training, and ongoing support. Their competency must be verified to ensure that bed system evaluations are performed in accordance with the HC guidance document, including correct use of the testing tool and accurate documentation of results.

6) Educate all nursing staff about the bed safety program developed under step (1) of this compliance order. Education must include an orientation to the entrapment zones on a bed system and consideration of the different types of rails in use throughout the home, key body parts at risk for entrapment, assessing residents for risk of entrapment, and entrapment zone testing methods in general.

A written record must be kept of everything required under this compliance order until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that where bed rails were used, the resident's bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During the inspection, the inspector observed a sizeable opening within the perimeter of a bed rail that was in use by a resident.

During an interview, the Director of Care (DOC) indicated that no bed system in the long-term care home, including that specific resident, had been evaluated in accordance with prevailing practices, as they had not been aware of the relevant requirements.

Sources: observations of the inspector, and interview with the DOC.

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #003 Air temperature

NC #016 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) Educate all staff, who monitor and measure air temperatures in the home, within seven days of receiving this report, on the procedure of monitoring and documenting the air temperatures and the required actions if the air temperatures in the home fall below 22 degrees Celsius.

2) Document the education provided including a description of the education provided, the name of the staff member receiving the education, the date the education was provided and who provided the education.

3) Conduct weekly audits of air temperature logs for three consecutive weeks to ensure compliance with the procedure.

4) Take immediate corrective action if deviations from the procedure are identified.

5) Maintain a written record of everything required under this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that that the air temperatures of the home were maintained at a minimum of 22 degrees. Specifically, during the period from July 29, 2025 to August 26, 2025, temperatures were below 22 degrees.

During a review of the homes air temperature logs, it was noted that on July 31, 2025, dining room temperatures were below 22 degrees Celsius. They were 20.84, 20.95 and 20.97.

On August 6, 2025, all of the air temperatures were significantly lower than 22 degrees. The range was between 15.31-17.75 degrees. On August 7, 2025, air temperatures were significantly lower than 22 degrees. They ranged between 16.83 and 18.70 degrees. On August 18, 2025, air temperatures were below 22 degrees. They ranged between 21.10-21.80 degrees. On August 21, 2025, the air temperatures were significantly lower than 22 degrees. They ranged between 13-24 degrees.

During inspector observations on August 28, 2025, at 0905 hours, air temperatures of three resident rooms and one dining room were below 22 degrees:

-In a specific room, the temperature was 21.6 degrees Celsius, in another room, the temperature was 19.8 degrees Celsius and in another room , the temperature was 19.9 degrees Celsius; and,
-In a specific dining room, the temperature was 21.9 degrees.

It was also noted that many residents were wearing sweaters, coats and had blankets covering themselves.

During an interview with a resident, they expressed that they, along with other residents have to wear heavy sweaters to stay warm. They also keep a heater on in their room to keep the room a little warmer.

During an interview with an Environmental staff, they confirmed that some air temperatures have been extremely below 22 degrees.

Sources: Homes air temperature logs, inspector observations, interviews with an Environmental staff and a resident.

This order must be complied with by October 14, 2025

COMPLIANCE ORDER CO #004 Air temperature

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Implement a procedure, within seven days of receiving the licensee report, for ensuring that air temperatures are measured and documented during all required legislative times. (Once every morning, once between 12-5pm and once every evening or night).

2) Educate all staff who will be monitoring and measuring air temperatures during the times mentioned above.

3) Document the education provided including a description of the education provided, the name of the staff member receiving the education, the date the education was provided and who provided the education.

4) Conduct weekly audits of air temperature logs for three consecutive weeks to ensure compliance with the procedure.

5) Take immediate corrective action if deviations from the procedure are identified.

Maintain a written record of everything required under this compliance order from 1-5, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that air temperatures are measured and documented at least once every morning, once every afternoon between 1200

hours and 1700 hours, and once every evening or night.

Specifically, the home has not measured and documented any air temperatures once every evening and night. On August 12, 2025, the air temperatures between 1200 hours and 1700 hours were not measured and documented. On August 2, 3 and 4, 2025 there were no documented air temperatures.

Sources: Homes air temperature logs, interview with an Environmental Services staff and and two Registered Nursing staff.

This order must be complied with by October 14, 2025

COMPLIANCE ORDER CO #005 Housekeeping

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Ensure that any personal support worker (PSW) who is hired following the receipt of this compliance order receives infection prevention and control training that includes education related to relevant cleaning and disinfection practices as part of their orientation training, before performing their responsibilities. Specifically, ensure that they are trained on the licensee's procedures for the cleaning and disinfection of resident care equipment (specifically, portable resident lifts and tubs) using, at a minimum, a low level disinfectant in accordance with evidence-based and/or prevailing practices. Maintain records of training, including the names of the staff members who were trained, the date of training, and the name of the person who provided the training.

2) Re-train PSWs on the licensee's procedures for the cleaning and disinfection of resident care equipment (specifically, portable resident lifts and tubs) using, at a minimum, a low level disinfectant in accordance with evidence-based and/or prevailing practices. Maintain records of training, including the names of the staff members who were trained, the date of training, and the name of the person who provided the training.

3) After the training under step (2) has been completed, conduct audits for three consecutive weeks to ensure that the portable resident lifts and tubs are cleaned and disinfected in accordance with the licensee's procedures. At a minimum, ensure that audits are completed once per shift, weekly, during the auditing periods. If deviations by staff from the licensee's cleaning and disinfection procedures are identified, take immediate action as required.

4) Ensure that the required cleaning and disinfectant product (s) are readily available for use by PSW staff when required.

Maintain a written record of everything required under steps (1), (2) and (3) of this

compliance order until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that procedures for the cleaning and disinfection of resident care equipment using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, were implemented.

The inspector observed a staff member to move, with a portable resident lift, from one resident room to another resident room without cleaning and disinfecting the lift between residents.
Personal Support Workers (PSWs) who were interviewed during the inspection described cleaning and disinfecting lifts only once per shift, or not at all. A PSW indicated that they occasionally used hand sanitizing wipes to clean lifts, such as when the lift was being used by more than one resident on their shift.

During the inspection, the inspector observed a PSW to be cleaning and disinfecting the shared tub on a specific Wing. The disinfectant product used was wiped and rinsed away immediately following its application, although it was to remain on the tub surface for ten minutes for the purpose of disinfection.

Sources: observations of the inspector, and interviews with several PSWs, with an Environmental Services staff/Housekeeping staff and Registered Nursing staff.

This order must be complied with by October 14, 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.