

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: December 17, 2025

Inspection Number: 2025-1364-0007

Inspection Type:

Complaint
Critical Incident

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Granite Ridge Community, Stittsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19-21, 24-28, 2025 and December 1-5, 8-12, and 15-17, 2025.

The following intakes were completed in this Critical Incident (CI) inspection:

Intake: #00156118 - related to a missing resident who had a fall resulting in injury

Intake: #00157871; Intake #00159210; Intake: #00161605; Intake: #00162171 - related to fall of a resident resulting in an injury

Intake: #00159459 – related to allegation of neglect of a resident by staff

Intake: #00159833; Intake: #00163045 – related to improper/incompetent care of a resident by staff

Intake: #00162806 – related to physical abuse of a resident by another resident

The following intakes were completed in this complaint inspection:

Intake: #00154811 – Complaint related to concerns of medication rights of a resident

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Intake: #00159398 – Complaint related to concerns of the resident's plan of care, skin and wound, allegation of neglect and communication and response system
Intake: #00159820 – Complaint related to concerns of medication error and allegation of neglect of a resident

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

- Resident Care and Support Services
- Medication Management
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Reporting and Complaints
- Falls Prevention and 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: FLTCA, 2021, s. 6 (1) (a)

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,

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(a) the planned care for the resident;

In December 2025, the DOC provided a copy of the resident's written plan of care that had been revised to include clear directions for the use of the chair alarm.

Remedied in December 2025.

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; and

A resident was assessed as a moderate risk for falls, the plan of care documented the resident was at a high risk for falls but the staff stated the resident was at low to moderate risk for falls.

Sources: Resident's electronic health record, interviews with a Personal Support Worker (PSW), Registered Nurse (RN) and the Director of Care (DOC).

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

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to the resident as specified in the plan.

In December 2025, a resident was observed not wearing their hip protectors as specified by the care set out in their plan of care.

Sources: Inspector's observation, resident's care plan and an interview with a PSW and an RN.

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #004 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.

A resident was identified as a high risk of falls with falls prevention strategies. PSW's who provide care for the resident were not aware of the content of the resident's plan of care specifically the resident's fall status and fall prevention strategies.

Sources: Interview with two PSW's, resident's care plan and the resident's fall risk assessment.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

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

A resident's written plan of care directed the use of a bed alarm while the resident was in bed as an intervention for fall management. In December 2025, an inspector observed that the resident did not have a bed alarm. A PSW confirmed that the resident had ongoing one to one staff supervision as a result of a fall in October 2025, and no longer required a bed alarm. An RN confirmed changes to the resident's care needs and that this should have been reflected in their documented care plan.

Sources: Critical Incident Report (CIR), resident's clinical records, interviews with a PSW and RN.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

A resident's plan of care for falls prevention and management had not been

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reviewed and revised when the resident had multiple falls in 2025 and the plan of care was not effective.

Sources: Resident's electronic health record, interviews with an RPN and an ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The written policy to promote zero tolerance of abuse and neglect of residents was not followed in October 2025 when the home was notified of an allegation of neglect of a resident.

The policy directed the Nurse to immediately upon becoming aware of an incident, assess the resident's safety and physical wellbeing and to notify the most responsible practitioner(s) for each resident involved.

In October 2025, the interim Executive Director, the interim DOC and the Associate Director of Care were notified of an allegation of neglect of a resident. The resident was assessed in October 2025, two days after being notified. The ADOC confirmed that the physician for the resident was not notified of the allegation of neglect.

Sources: The home's prevention of abuse and neglect policy, Critical Incident Report

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and email correspondence from October 2025, the resident's progress notes and an interview with the ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home was notified of an allegation of neglect to a resident in October 2025, which was not reported immediately to the Director. The incident was reported two days later.

Sources: Critical Incident Report (CIR) and an interview with the ADOC.

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 36 (4) 1.

PASDs that limit or inhibit movement

s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where

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appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

The plan of care identified that the tilt on the wheelchair was used to assist a resident with locomotion and repositioning, however there was no indication that alternatives had been considered and tried prior to its use, as confirmed by the ADOC.

Sources: The resident's electronic health record and an interview with the ADOC.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (7) 6.

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:

6. Any other areas provided for in the regulations.

Pursuant to O. Reg. 246/22, s. 261 (1) 1, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, falls prevention and management.

Pursuant to O. Reg. 246/22, s. 261 (2), The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act, annually.

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A PSW who provided direct care to residents, did not receive additional training annually, specifically related to falls prevention and management, as a condition of continued contact with residents.

Sources: Interviews with a PSW and the Executive Director (ED).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A staff member attempted to assist a resident to a sitting position by pulling on their arm, as observed in a video footage in October 2025. The ADOC confirmed that it was not a safe transferring and repositioning technique.

Sources: Review of video recording, interviews with PSW and ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the

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review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which must at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, and that it must be complied with.

The Home's Falls Prevention & Management policy contained directions on page 2 stating: The Nurse Will:

3.-Upon completion of the detailed fall risk assessment, update the plan of care with resident specific fall prevention interventions based on interprofessional input.

Strategies from the licensee's falls prevention and management program was not implemented for a resident when the resident was admitted to the home and had a high risk for falls.

Sources: Resident's electronic health record, homes Falls Prevention & Management policy, interviews with a PSW and the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 103 (d)

Policy to promote zero tolerance

s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,

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(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed to promote zero tolerance of abuse and neglect of residents were complied with.

The licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents that identifies the manner in which allegations of abuse and neglect will be investigated was not complied.

After an alleged incident of abuse or neglect of a resident, the home did not initiate the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the even.

Source: Interview with the ADOC and the home's prevention of abuse and neglect policy and checklist.

WRITTEN NOTIFICATION: Police notification

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

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The appropriate police service was not immediately notified of the alleged incident of abuse or neglect of a resident in October 2025, as confirmed by the ADOC.

Source: Resident's electronic health record, interview with an RPN and the ADOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The acknowledgement letter for the complaint in regards to a resident that was provided within 10 business days of receipt of the complaint, did not include the date by which the complainant could reasonably expect a resolution.

Sources: Resident's electronic health record, Home's response letter to the complainant and interview with the ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

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NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

3. A resident who is missing for three hours or more.

In August 2025, the Director was not immediately inform when a resident was missing, as confirmed by the interim DOC.

Sources: The After Hours report and an interview with the interim DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (6)

Reports re critical incidents

s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

The resident's substitute decision-maker (SDM) was not promptly notified when the resident had a change in health status in October 2025. The ADOC stated that the SDM was expected to be notified at the time of the incident, however, the documentation showed the SDM was not contacted until the physician visit later

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that day.

Sources: Resident's electronic health record, interviews with the RPN and the ADOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

In September, October, and November 2025, a medication was found on the resident that had not been removed as per the prescriber specification.

Sources: Home's file on medication incidents for the resident and an interview with the ADOC.

WRITTEN NOTIFICATION: Recreational cannabis

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 142 (1)

Recreational cannabis

s. 142 (1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

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In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the recreational cannabis program were complied with. Specifically, the home's recreational substances policy, stated that the Executive Director (ED) and/or Director of Care (DOC) will conduct a risk assessment, the nurse will ensure recreational substances/materials are stored in a secure area at all times, and update the resident's plan of care regarding the resident's choice and use of recreational substances.

Specifically, in August 2025, staff were made aware that a resident was engaging in recreational cannabis use. The interim DOC confirmed that no risk assessment was conducted for the resident. Progress notes confirm that a lock box to store the cannabis securely was provided to the resident days later, and the resident's documented care plan was updated to reflect the resident's use of cannabis 15 days after initial use and possession.

Sources: The recreational substances policy, resident health care records, interview with the interim DOC.

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 356 (5)

Construction, renovation, etc., of homes

s. 356 (5) A licensee who has received the Director's approval under subsection (3) shall ensure that the work is carried out in accordance with the plan or specifications and work plan provided under subsection (4).

The Director approved the licensee's work plan for painting of common areas. The

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approved operational plan stated that safety measures for residents would be in place, including all areas scheduled for painting would be fully enclosed with floor-to-ceiling poly sheeting to prevent the spread of dust, paint particles, and fumes into resident and staff areas.

In November 2025, an inspector observed that the work was not being carried out in accordance with the plan. The painting had commenced in the common areas between two resident home areas. During multiple observations, residents were in the common area while construction was being completed without floor-to-ceiling poly sheeting enclosures, as indicated in the approved operational plan.

The ED confirmed that construction would be stopped until poly sheeting was applied as per operational plan.

Sources: Approved operational plan for painting and observations made by the inspector.

COMPLIANCE ORDER CO #001 Air temperature

NC #021 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 prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to: The licensee will prepare and implement a plan that will ensure that the home is maintained at a minimum temperature of 22

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degrees Celsius (C).

The plan will include, but not be limited to, the following:

- A. Investigate the cause of the low air temperatures in the five identified bedrooms and implementation of corrective measures.
- B. Review and update the licensee's written air temperature monitoring procedure to include details about calibrating the equipment used for measuring temperatures and process to follow to measure the temperature.
- C. Ensure staff are measuring the air temperature in areas of the bedroom where residents primarily sleep or rest, such as at the bedside table or armrest of a comfortable easy chair.
- D. Within one week of receiving this Compliance Order (CO), measure and document the air temperatures using a calibrated device following the procedure referenced in item (B).
- E. Implement corrective actions, including defined interventions, to ensure resident safety and comfort if temperatures fall below 22°C.
- F. Starting two weeks after receiving this CO, implement an enhanced monitoring program to measure and document air temperature in every bedroom (or bedspace in shared rooms) at least once per week. Continue this program until such time that the Ministry of Long-Term Care deems this CO to be in compliance.
- G. As relevant to staff member's responsibilities, provide refresher training about the licensee's obligation to maintain the home at a minimum temperature of 22°C,

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including their role (if any) in monitoring and reporting temperatures below the minimum for immediate follow-up. Include review of the written procedure for measuring air temperatures with calibrated equipment.

H. Maintenance of detailed records of all aspects of the plan. For example; training dates, content, participants, trainer; temperature audit dates and approximate time, locations and corrective actions.

Please submit the written plan for achieving compliance for inspection #2025-1364-0007 to the LTC Homes Inspector, MLTC, by email to ottawadistrict.mltc@ontario.ca by December 29, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The home was not maintained at a minimum temperature of 22 degrees Celsius (C).

In December 2025, an inspector observed that two residents' rooms were below the required temperature at 20.5 C and 21 C respectively. On another date in December 2025, the inspector observed three residents' rooms were below the required temperature, at 21.2 C, 18.8 C and 20.5 C.

The Maintenance Manager (MM) stated that the home has an air temperature monitoring program; however, the rooms found by the inspector to be below 22°C were not captured through the established process. The MM indicated that they would contact a contractor to resolve the lack of heat in the five residents' bedrooms.

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Sources: Observations made in resident home areas using a thermometer to measure air temperature and an interview with the Maintenance Manager.

This order must be complied with by **January 9, 2026**

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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

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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:

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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
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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.