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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: September 15, 2025

Inspection Number: 2025-1709-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Humber Meadows Long-Term Care Home

Long Term Care Home and City: Humber Meadows Long-Term Care Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21, 22, 25, 26, 28, 29, 2025 and September 2 to 4, 9, 15, 2025
The inspection occurred offsite on the following date(s): August 27, 2025 and September 2, 5, 8, 11, 12, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-Intake: #00150188 - CI #3065-000035-25 - Related to Fall prevention and Management
-Intake: #00152815 - CI #3065-000040-25 - related to Palliative care
-Intake: #00153122 - CI #3065-000041-25 - related to Medication Management
-Intake: #00154281 - CI #3065-000045-25 - related to Infection Prevention and Control

The following intake(s) were inspected in this Complaint inspection:
-Intake: #00154889 - Complaint related to Reporting and complaints, Fall Prevention and Management
-Intake: #00151414 - Complaint related to Prevention of Abuse and Neglect, Maintenance Services
-Intake: #00153705 - Complaint related to Palliative Care, Maintenance Services, Medication Management, Pain Management

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

Resident Care and Support Services

Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints
Palliative Care
Pain Management
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: 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 the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The home has failed to ensure that there was posted signage throughout the home in accordance with the “IPAC Standard for Long Term Care Homes September 2023” (IPAC Standard). Specifically, no signs were posted that listed the signs and symptoms of infectious diseases for self-monitoring as required by Additional Screening requirements 11.6 under the IPAC Standard throughout the home.

It was observed that the above signage was posted at the entrance but not throughout the home on August 21, 2025. The IPAC Lead verified this and then placed the signage in the elevators and at the entrances to Resident Home Areas on August 22, 2025.

Sources: Observations and an interview with the IPAC Lead.
[501]

Date Remedy Implemented: August 22, 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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of their pain, so that their assessments were integrated and were consistent with and complemented each other.

The homes policy “Medication Administration" identified that nurses are to notify the physician (MD) when the pro re nata (PRN) medications administration results are not effective.

A resident experienced pain during an evening shift but the PRN medication given was ineffective. The MD was not informed of the resident's ongoing pain and that the medications used to treat it were not effective until the following morning.

The Resident Home Area Nurse Manager (RHA NM) and the Director of Care (DOC) indicated that it was the home's protocol to notify the MD of a resident's pain symptoms not relived by pain medication.

Sources: Review of a resident's Medication Administration Record (MAR), Long Term Care Home's (LTCH) policy "Medication Administration" and interviews with the Registered Practical Nurse (RPN), RHA NM, the DOC and other 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 (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.

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when they returned from the hospital.

A resident had a fall and sustained an injury. When the resident's care needs changed including their mobility aid, the plan of care was not reassessed and revised, specifically for falls prevention and management.

RHA NM stated the fall interventions for the resident should have been implemented to help prevent injuries from further falls.

Sources: Critical Incident (CI), inspector's observations review of a resident written plan of care and interview with the RHA NM.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (12)
Plan of care
s. 6 (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care.

The licensee has failed to ensure that a resident's family member was given an explanation of the resident's plan of care.

A resident's family member voiced their concern to the home regarding the resident's skin alterations. The home investigated and found that the resident had ongoing skin concerns that were being assessed and monitored. The resident's plan of care was updated that stated staff were to educate the Substitute Decision Maker (SDM) and family on the etiology of skin alterations and consider the support that the family could offer to promote healing.

The home's Medical Director identified the potential causes of the resident's altered skin condition, and stated the family should have been kept aware of the causes. RHA NM confirmed the home should have explained the cause of the skin alterations and the plan of care.

Sources: The home's investigation notes, review of resident's written plan of care, and interviews with the home's Medical Director and RHA NM.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was immediately informed after an allegation of improper care for a resident.

An allegation of improper care was forwarded to the Assistant Executive Director (AED) as an email complaint. The licensee did not inform the Director regarding the allegation

of improper care until two days later.

Sources: Review of home's investigation file, CI, interviews with the RHA NM.

WRITTEN NOTIFICATION: Cooling Requirements

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 policy titled "Prevention and Management of Hot Weather Related Illness", 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 and Family Council of the home.

Sources: LTCH's policy "Prevention and Management of Hot Weather related illness", interviews with the DOC and Executive Director (ED).

WRITTEN NOTIFICATION: Air Temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was consistently measured and documented in writing, in at least two resident bedrooms in different parts of the home, in one common area on every floor of the home, and in every designated cooling area in the home.

Maintenance Lead stated that air temperatures in resident bedrooms, common areas, and designated cooling areas are not documented in writing, as they have an automated system which can identify temperatures throughout the building. The automated system was not programmed to generate a report that identifies recorded temperatures for two resident bedrooms, one common area on every floor of the home, and every designated cooling area in the home as required by legislation. The written air temperature documentation process was implemented in September 2025.

Sources: Interviews with the Maintenance Lead and the ED.

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that the pain management program provided monitoring of a resident's responses to, and the effectiveness of, the pain management strategies.

The home's policy “Medication Administration" identified that nurses are to assess the resident within one hour after a "STAT", PRN or initial dose medication is given, to determine results.

1) A resident received a PRN medication. A review of the Medication Administration Record (MAR) and progress notes confirmed that a reassessment was not completed within one hour after the administration of the PRN medication. According to a RPN, they did not return to the resident to assess their response to and the effectiveness of the pain medication. The resident continued to experience symptoms, and the nurse determined the medication was ineffective.

2) A resident received a PRN medication. A review of the MAR and progress notes confirmed that a reassessment was not completed within one hour after the administration of the PRN medication. A Registered Nurse (RN) stated that they did not go back to the resident to monitor their response to and the effectiveness of the pain medication, and the nurse determined the medication was ineffective.

Sources: Review of a resident’s clinical records, LTCH's policy " Medication Administration", and interviews with a RN and RPN.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that written complaints sent to the home concerning the care of a resident were investigated and resolved where possible, and a response was provided within 10 business days of the receipt of the complaint.

A resident's SDM submitted a written complaint to the AED outlining care concerns. Record reviews confirmed there was no documentation indicating that a written response was provided to the complainant.

The DOC confirmed no written response was provided to the complainant.

Sources: LTCH's policy titled “Complaints Management Program”, written complaint letter, and interview with the DOC.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #010 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,

The licensee has failed to ensure that a breakdown of major equipment in the home affecting the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, was reported to the Director.

The home experienced air cooling system failure on a specified date, which was not resolved until the following day. The Director was not informed of the breakdown of this system..

Sources: Service repair reports, and interviews with the ED and other staff.

WRITTEN NOTIFICATION: Medication Management System

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that their written policy related to medication management was complied with.

Specifically, the registered staff did not implement the home's policy titled "Medication Administration" which stated that during medication administration, staff should document on the MAR for each medication administered.

On multiple occasions, the nursing staff did not document the administration of a medication in the MAR

The RHA NM and DOC acknowledged that staff were not following the medication administration policy.

Sources: Review of MAR for a resident; review of LTCH policy " Medication Administration ", and interviews with a RN, RPN, RHA NM, and the DOC.

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that RPNs reported the medication incident involving a resident to the resident's SDM, attending physician, Medical Director, the Director of Nursing and Personal Care, and the pharmacy service provider when a medication was not administered to the resident on three identified dates.

Sources: Review of a resident's clinical records, home's investigation notes, home's policy titled "Policies & Procedures, Manual for Medisystem Serviced Homes", interviews with the RPNs and RHA NM.

COMPLIANCE ORDER CO #001 Duty to Protect

NC #013 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)]:

1. Complete a comprehensive interdisciplinary review and analysis of a resident's missed medication doses for an identified period, in relation to the home's relevant policies and procedures. The purpose is to determine contributing factors, identify potential opportunities for improvement, document the outcome of the analysis, and

implement corrective actions based on post-analysis learnings (if applicable), in collaboration with the home's pharmacy consultant. Maintain a record of this review and analysis, including meeting minutes, the date(s) it was completed, the names and signatures of participants/attendees, and any relevant records, policies, or procedures used during the review.

2a. Upon completion of item 1, conduct in-person education sessions using the medication incidents as a case study with all registered staff assigned to an identified unit. The education should include the contributing factors, opportunities for improvement, and any practice changes resulting from lessons learned from the completed review and analysis (if applicable).

2b. As part of the training described in item 2a, include instruction for registered staff on confirming medication availability during medication pass, signing only for medications that were actually administered, how to reorder medications during and outside of the pharmacy’s regular hours, and the steps to take when a medication dose is missed, including but not limited to initiating the medication incident reporting procedures.

3a. Conduct random audits of a resident’s medication availability and doses on hand. These audits should track the date and amount dispensed by the pharmacy, verify the number of tablets available for administration, and compare this to the amount documented as administered to ensure the resident is receiving the medication in accordance with the prescriber’s directions. Audits must be conducted at least twice per week, with one audit during the day shift and one during the evening shift, for four weeks following the service of this order.

3b. Maintain a record of all audits, including all components outlined in item 3a, the name of the person conducting the audit, the date and time of each audit, the staff members audited, the audit findings, any discrepancies noted, and actions taken in response to the audit findings.

Grounds

1a. The licensee has failed to ensure that a resident was not neglected by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or

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

A resident had a medical diagnosis which required a prescribed medication to be administered at specified times and intervals.

Record reviews revealed that the resident was not administered multiple doses of the medication over an extensive period of time, however the nurses documented the medications were administered. The resident experienced negative health outcomes during this period.

The attending Physician and RHA NM confirmed that registered staff signed the MAR, although not all doses they signed for were administered, which may have contributed to the resident's negative health outcomes.

Missing multiple prescribed doses of the medication, increased the resident's risk of further health complications.

1b. A resident's MAR indicated that a medication was not available on four identified shifts. The home's policy titled "Policies & Procedures, Manual for Medisystem Serviced Homes," noted that the after-hours pharmacist is available for urgent medication needs when the pharmacy is closed and the medication is not in the Emergency Drug Box at the home. However, the nurses did not contact the after-hours pharmacist or explore alternative options to obtain the medication.

Failing to contact the after-hours Pharmacist resulted in missed doses of the medication, placing the resident at increased risk for adverse health outcomes.

1c. A resident's MAR indicated that a medication was not administered on four identified shifts, due to medication unavailability. The home's policy, titled "Policies & Procedures, Manual for Medisystem Serviced Homes," identifies missed doses as medication incidents that require immediate action, including providing resident care, implementing harm prevention measures, reporting to the DOC and pharmacy, and completing a medication incident report before the end of the shift. Three nurses did not follow these procedures, hence there were no resident care actions taken to mitigate risk to the resident. When staff failed to follow the home's medication management policy, it increased the risk of delayed corrective measures and subsequent adverse health

outcomes.

Sources: Review of a resident's clinical records, home's investigation notes, home's policy titled "Policies & Procedures, Manual for Medisystem Serviced Homes", interviews with the RPNs, Pharmacy Consultant, RHA NM and the Attending Physician.

2. The licensee has failed to protect a resident from emotional abuse by a Personal Support Worker (PSW).

Section 2(1)(a) of the Ontario Regulation 246/22 defines emotional abuse as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment, or infantilization performed by anyone other than a resident.

A resident expressed concerns about care they received from a PSW, which was reported to a RPN and the PSW. The PSW confronted the resident for reporting them, and made additional negative comments to the resident. The resident reported feeling upset by the PSW comments. The RHA NM acknowledged that the comments made to the resident were not appropriate.

Sources: Review of a resident's clinical records, home's complaint record, interview with a resident, PSW and the RHA NM.

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #002 Air Conditioning Requirements

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (3) 1.
Air conditioning requirements
s. 23.1 (3) The licensee shall ensure air conditioning is operating, and is used in accordance with the manufacturer's instructions, in each area of the long-term care home described in subsection (1) in either of the following circumstances:
1. When needed to maintain the temperature at a comfortable level for residents during the period and on the days described in subsections (1) and (2).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 23.1 (3) 1. [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1a. Complete a review of the supplementary cooling options that can be in operation to ensure resident rooms are maintained at a cool and comfortable temperature where indicated. This review should also assess all other measures in the home's heat related illness prevention and management plan. Following the review, develop a plan to identify any other services or equipment needed to support implementation of the home's heat related illness prevention and management plan, and identify any opportunities for improvement and corrective actions, if applicable.

1b. Maintain a record of this review including meeting minutes, the date(s) it was completed, the names and signatures of participants/attendees, and any relevant records, policies, or procedures used during the review, as well as the outcome or corrective actions following the review.

2. A process to ensure that resident rooms have cooling options installed during the period of May 15 to September 15 of each year and on any day where 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.

3. A process to report to the Director whenever there are any breakdowns of major equipment in the home affecting the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours as provided in the legislation.

Please submit the written plan for achieving compliance for inspection #2025-1709-0005 to LTC Homes Inspector, MLTC, by September 26, 2025.

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

Grounds

The licensee has failed to ensure the air conditioning system was able to maintain comfortable indoor air temperatures for residents during hot days, especially when

indoor temperatures for resident rooms exceeded 26 degrees Celsius (°C).

Environment and Climate Change Canada forecasted maximum temperatures in the City of Toronto on specified days, of up to 33.7°C.

A resident's family member reported that the resident's room air temperature was elevated. The room remained hot overnight, causing discomfort for the resident. Two standing fans were provided, however they were ineffective in cooling the room, which reached temperatures above 28˚C.

The Building Automated System (BAS) data confirmed that the room temperature remained above 26° C. The resident's heat risk assessment score flagged for increased risk for heat related illness.

Furthermore, multiple maintenance requests were logged regarding excessive heat in other resident rooms. Staff reported residents complaining about their room being were very hot during this period.

The AED stated that during this time, the Air Cooling chillers were not functional and required service repair.

Failure to ensure that the air conditioning system was functional affected the comfort and wellbeing of residents, and placed them at increased risk of heat related illness

Sources: Environment and Climate Change Canada data, Review of maintenance log, BAS air temperature records for a resident, interviews with the AED, ED and other staff.

This order must be complied with by November 7, 2025

COMPLIANCE ORDER CO #003 Air Temperature

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (4)
Air temperature
s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,
(a) every day during the period of May 15 to September 15; and
(b) every other day during 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.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 24 (4) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

1. Develop and implement a process to ensure that temperatures are measured and documented daily between 12 p.m. and 5 p.m. in every resident bedroom without functioning air conditioning from May 15 to September 15, and on days when Environment and Climate Change Canada forecasted temperatures of 26°C or higher.

2a. Develop and implement a plan to retrain all Maintenance staff, Management staff, and any other staff who is responsible for taking room temperatures on the home's process for temperature measurements in accordance with the legislation. This plan should include how new staff being oriented to the maintenance department will also be trained to comply with the temperature measuring requirements.

2b. Keep a written record of the education provided, including but not limited to the name of the person providing the education, the date the education was delivered, the names of staff in attendance, and the education content and materials used.

Please submit the written plan for achieving compliance for inspection #2025-1709-0005 to LTC Homes Inspector MLTC, by September 26, 2025.

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

Grounds

The licensee has failed to ensure that the temperatures were measured and documented in writing once daily between 12 p.m. and 5 p.m. in every resident bedroom without functioning air conditioning from May 15 to September 15, and on days when Environment and Climate Change Canada forecasted temperatures of 26°C or higher.

On specified dates, the home's air conditioning systems experienced breakdowns, affecting several resident bedrooms. During this period, Environment and Climate Change Canada forecasted maximum temperatures in the City of Toronto of up to 33.7°C.

Several residents reported discomfort, including a resident who was identified as high risk for heat related illness.

The ED and Maintenance Staff acknowledged the daily temperature readings were not documented in the affected rooms.

Failure to monitor and record room temperature in the resident rooms impacted by the cooling system breakdown prevented the home from identifying residents have required heat related interventions.

Sources: Environment and Climate Change Canada data, LTCH's policy " Heat Contingency & Air Temperature Monitoring Protocols (ON), interviews with the Maintenance staff, ED, and other staff.

This order must be complied with by November 7, 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.