

Ministry of Long-Term Care

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

Central West District

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

Public Report

Report Issue Date: September 4, 2025

Inspection Number: 2025-1833-0005

Inspection Type:

Complaint
Critical Incident
Follow up

Licensee: CVH (No. 2) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Southbridge Goderich, Goderich

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 18-20, 22, 25-28, 2025 and September 3-4, 2025

The following intake(s) were inspected:

- Intake: #00148831, Intake: #00153778 related to resident-to-resident abuse
- Intake: #00149706 - Follow-up #: 1 - O. Reg. 246/22 - s. 34 (2), CDD August 18, 2025
- Intake: #00149707 - Follow-up #: 1 - O. Reg. 246/22 - s. 108 (1) 1. CDD, August 18, 2025
- Intake: #00149708 - Follow-up #: 1 - FLTCA, 2021 - s. 16, CDD August 18, 2025
- Intake: #00149709 - Follow-up #: 1 - FLTCA, 2021 - s. 3 (1) 19. iv. CDD, August 18, 2025
- Intake: #00149710 - Follow-up #: 1 - O. Reg. 246/22 - s. 90, CDD August 18, 2025
- Intake: #00149711 - Follow-up #: 1 - O. Reg. 246/22 - s. 74 (2) (b), CDD August 18, 2025

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- Intake: #00149712 - Follow-up #: 1 - FLTCA, 2021 - s. 71 (a), CDD August 18, 2025
- Intake: #00149713 - Follow-up #: 1 - O. Reg. 246/22 - s. 57 (1) 4., CDD August 18, 2025
- Intake: #00150358, Intake: #00151310, Intake: #00154629 related to resident falls
- Intake: #00152688 related to improper care
- Intake: #00152978 related to a complaint regarding concerns of care
- Intake: #00155166 related to a complaint regarding air temperatures and dietary services

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #004 from Inspection #2025-1833-0001 related to O. Reg. 246/22, s. 34 (2)

Order #002 from Inspection #2025-1833-0001 related to FLTCA, 2021, s. 16

Order #001 from Inspection #2025-1833-0001 related to FLTCA, 2021, s. 3 (1) 19. iv.

Order #007 from Inspection #2025-1833-0001 related to O. Reg. 246/22, s. 90

Order #006 from Inspection #2025-1833-0001 related to O. Reg. 246/22, s. 74 (2) (b)

Order #003 from Inspection #2025-1833-0001 related to FLTCA, 2021, s. 71 (a)

Order #005 from Inspection #2025-1833-0001 related to O. Reg. 246/22, s. 57 (1) 4.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #008 from Inspection #2025-1833-0001 related to O. Reg. 246/22, s. 108 (1) 1.

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

- Resident Care and Support Services
- Food, Nutrition and Hydration
- Residents' and Family Councils
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards
- Reporting and Complaints
- Residents' Rights and Choices
- Pain Management
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 to the resident as specified in the plan.

The licensee failed to ensure that the care set out in a resident's plan of care was provided to them.

A resident required additional positioning techniques to be implemented while sitting and in bed. The resident was observed on separate occasions without the

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positioning technique in place.

Sources: Resident's care plan and progress notes, observations, interviews with resident and staff

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 home failed to immediately report an allegation of improper or incompetent treatment of a resident to the Director.

Sources: Review of resident clinical record, interview with staff

WRITTEN NOTIFICATION: Conditions of licence

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

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

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The licensee failed to comply with an order under the Act.

A compliance order under the Regulation 246/22 s. 108 (1) (1) Dealing with complaints was issued to the home on June 10, 2025. The home was to ensure all managers directly responsible for supervision of resident care were provided education in relation to what may constitute an allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident and steps to be taken based on the home's investigation policies and procedures.

On August 28, 2025, the Clinical Consultant confirmed the education material provided to staff had not referenced what may constitute an allegation of improper or incompetent treatment of a resident. Steps to be taken based on the home's investigation policies and procedures were not included in staff training related to the compliance order.

Sources: Interviews with staff and review of education

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

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required to pay an administrative penalty of \$1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

CO was issued for Reg. 246/22 s. 108 (1) (1) Dealing with complaints, June 10, 2025 #2025_1833_0001

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Cooling requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23 (2) (d)

Cooling requirements

s. 23 (2) The heat related illness prevention and management plan must, at a minimum,

(d) include the use of air conditioning, cooling equipment and other resources, as

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necessary, to protect residents from heat related illness; and

The licensee failed to ensure their heat related illness prevention and management plan contained air conditioning, cooling equipment and other resources, as necessary, to protect residents from heat related illness.

Care staff were unaware of supplemental cooling equipment, including air conditioners, available at the home when needed. Environmental Service Management staff noted supplemental cooling equipment for resident use in the event of air conditioning concerns was not on site at the time of inspection.

Sources: Interviews with environmental consultant and other staff, policies related to heat-related illness

WRITTEN NOTIFICATION: Cooling requirements

NC #005 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 failed to ensure their heat related illness prevention and management plan contained a protocol for appropriately communicating the heat related illness prevention and management plan to residents, staff, volunteers, substitute decision-

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makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. The plan included for a communication plan to be created at the time of implementation.

Sources: Interviews with environmental consultant, policies related to heat-related illness

WRITTEN NOTIFICATION: Maintenance services

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

Non-compliance with: O. Reg. 246/22, s. 96 (2) (c)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

The licensee failed to ensure procedures were developed and implemented for inspection of the home's ventilation and air conditioning systems every 6 months by a certified individual, and documentation of the inspection was maintained.

The systems had not been inspected by a certified individual within a 6 month period, and were scheduled to be inspected on an annual basis.

Sources: Interview and correspondence with environmental service staff

COMPLIANCE ORDER CO #001 Duty to protect

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NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee shall:

- 1) Audit the identified Personal Support Worker (PSW) on three different occasions to ensure that care provided was per the residents care plan.
- 2) At least weekly, audit PSWs on the identified home area to ensure that care provided was as per the residents care plan. Ensure all shifts are captured in the audits.
- 3) Document the date and time of the audits and any corrective action taken to address actions or inactions of PSWs in Part 1 and 2.
- 4) Ensure that the physician of the identified resident was notified of the incident on the specified date. Consider the physician's input and the resident's history in referring to an external Behavioral Supports Ontario (BSO) or other behavioral resources to reassess the resident. Ensure that the physician documents this consideration.

Grounds

The licensee failed to ensure that a resident was protected from neglect, and that two residents were protected from abuse.

A) A resident was assessed as requiring assistance with mobility, including bed

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mobility. A staff member caring for the resident was aware of the appropriate assistance required to care for the resident, however they did not provide care as per the assessments.

After the resident had care provided to them, they were later found on the floor after falling and sustaining significant injuries.

Failure to provide care in a safe manner for the resident resulted in high impact when staff action contributed to their fall out of bed and significant injuries sustained.

Sources: Resident clinical records, interviews with staff, investigation notes, discipline letter

B) A resident was observed on two occasions acting inappropriately towards another co-resident, who removed the resident's hand from their proximity twice. The physician was not made aware of the incident.

Sources: Critical incident report, progress notes, investigation notes, resident records

C) A resident entered a co-resident's room and caused injury to them, requiring the co-resident to be transferred to hospital.

Sources: Interviews with staff, resident clinical records

This order must be complied with by October 16, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance

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order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #002

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

#2025_1833_0004 high priority CO for Duty to Protect FLTCA s. 24 (1) on August 6, 2025

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after

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service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Nursing and personal support services

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)

Nursing and personal support services

s. 35 (3) The staffing plan must,

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

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

The licensee shall:

- 1) Ensure there is a process to track, monitor and analyze staffing shortages for all categories of staff that provide direct care to residents (Registered Nurses, Registered Practical Nurses, Personal Support Workers). The process should include monitoring the impact to residents when staff have been required to work short.
- 2) The process should be documented and reviewed with the home's management team. Direct Care staff should be informed of the tracking and monitoring process.

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- 3) The documented process should be made available to an inspector upon request.
- 4) For one month, on a weekly basis, review what units and what shifts (if any) were short staffed. Complete an analysis on two units to determine how working short-staffed impacted the residents on the unit, what actions were taken to support the residents, and what actions were taken to support the staff working short. Ensure records are kept on the analyses completed, including when and who completed them.

Grounds

The licensee failed to comply with their staffing contingency plan when care was not provided to residents requiring two staff for bed mobility. Another resident was provided care with only one staff when they required two on a specific home area.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that the written contingency plan for staffing shortages is complied with.

Each resident home area was to have two PSW's on the night shift (2200hrs to 0600hrs). On a specified date, a home area was short one PSW to work.

The staffing contingency plan stated that the Registered Practical Nurse (RPN) was to assist the PSW with residents requiring two-person care. Other PSW's from fully staff units were to assist the home area when short staffed.

Staff stated they had not provided care to residents on the home area that required two person for care on the specified date until after 0230 hours the following day. They stated they had provided care to a resident alone, although they were aware the resident required two persons for care.

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A discipline letter given to a staff member stated they had not asked for assistance from other staff to care for a resident requiring two persons for care as outlined in the home's contingency plan.

There was high impact to a resident when staff provided care with one person and later the resident fell sustaining significant injury. There was potential impact to others when care was not provided for a period of time to residents requiring two staff for care.

Sources: Interviews with staff, review of clinical records for multiple residents, discipline letter, Critical Incident Report

This order must be complied with by October 16, 2025

COMPLIANCE ORDER CO #003 Policy to promote zero tolerance

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

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- 1) Ensure that the home follows their Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct, August 2025 policy related to investigating any allegation of resident abuse.
- 2) Review with those managers responsible for completing a resident abuse investigation, information to be completed and included in an investigation.
- 3) Review with those managers FLTCA 2021, s. 150, Powers on inspection, s. 153 Obstruction, etc. and ensure this legislation is adhered to.
- 4) Document the review, managers receiving the review, include the date, format, staff member who provided the review, and include a copy of the content of the information for review.
- 5) Audit 5 resident abuse investigation files between September 1st - October 16th, 2025 to ensure physicians and police have been notified per the home's abuse policy. Have audits available for inspector review and any corrective action taken.

Grounds

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the home did not comply with their investigation procedure as it related to notification of police after an incident that may have constituted a criminal offence, and utilization of appendices that included conducting interviews or receiving statements from witnesses involved and ensuring appropriate documentation of those statements.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policy that deals with resident abuse was complied with.

A) The home's investigation related to an incident of abuse was requested. The home's policy indicated two checklists that were to be used for all investigations.

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Both checklists were not fully completed or implemented and caused discrepancies in the actions taken during the investigation process.

Sources: Home's investigation notes, Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct policy

B) The home's investigation of an incident related to sexual abuse documented a staff member was interviewed with their union representative present. Information documented from their statement and provided to the Inspector did not align to the statement the staff member had provided to the Inspector. Neither the staff member nor the union representative recalled meeting with management.

Management said they had interviewed another staff member, but were unable to provide a documented interview.

In addition, police had not been notified of the alleged incident of sexual abuse. No checklist was provided to show what had been collected or completed for this investigation, however a different checklist was observed to be partially completed when Inspector was with management in their office.

When the home did not follow their policy by including witness statements and interviews, and notifying police of an alleged incident of sexual abuse, there may have been missed opportunity for the home to collect information for a fulsome investigation and follow up with areas identified that contributed to the incident and potentially put additional interventions in place to mitigate further risk.

Sources: Critical Incident Report, Progress notes, Policy: Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct, home's investigation notes, interviews with management and staff.

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C) An email was sent by an Inspector to management requesting all interviews, emails, any and all information related to the investigation of alleged incompetent care of a resident that was to have occurred on a specified date.

The home's investigation information provided was reviewed. No written statement from a staff member or interviews with other involved staff members were present in the information provided to the Inspector.

After being requested, management provided an original written statement about the incident from a staff member and interviews from other involved staff members related to the incident. These documents had not been provided to the inspector as part of the home's investigation.

When the home did not follow their policy by including witness statements and interviews, there may have been missed opportunity for the home to follow up with areas identified that contributed to the incident.

Sources: Interviews with staff and management, investigation file related to the incident

This order must be complied with by October 16, 2025

COMPLIANCE ORDER CO #004 Air conditioning requirements

NC #010 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

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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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Develop, implement, and document a process to identify which resident rooms are more likely to be impacted by elevated outdoor temperatures (when 26°C or higher). Once identified, document the room locations and include what actions or strategies are to be implemented by staff to ensure that resident room temperatures are adjusted to a comfortable level for residents, including when and how supplemental air conditioning equipment will be used. Ensure the identified resident rooms are included.

2) Review and revise the home's processes as needed to include written directions for maintenance and care staff in response to resident complaints regarding air temperatures. Ensure the processes include:

(A) Documentation of the resident air temperature concern with a date and time, nature of the concern, as well as which staff received and investigated the concern.

(B) Documentation of the response from staff, including what investigation was undertaken, and the results. Include the rationale for whether corrective actions were merited, as well as when they were taken. Include whether the concern was resolved, as well as subsequent actions if needed, and how the concern was determined resolved.

(C) Directions on when management is to be notified regarding air temperature concerns, and how, including which managers are to be notified. Ensure

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documentation is maintained of the notification, including the rationale for whether management notification was merited or not, as well as which members of management were notified and when if merited.

(D) How temperature logs will be monitored for completion and appropriate responses, including the frequency and personnel responsible.

3) Review and revise the home's Heat Related Illness Prevention and Management Plan for compliance with O.REG. 246/22 s. 23 (2) (d) and (e).

4) Provide education to maintenance and registered staff of the processes associated with sections 2 and 3 of the order. Maintain a record of the following:

(A) Dates the education was provided, the provider, and contents of education provided

(B) Signatures and/or records of attendance from staff for the education, including the date of completion.

(C) A list of the maintenance staff and registered staff required to receive the education during the period between report issue date and compliance due date.

Grounds

The licensee failed to ensure air conditioning was operating in resident rooms when needed to maintain the temperature at a comfortable level for residents between May 15 and September 15, on any day when outside temperatures (as forecasted by Environment and Climate Change Canada) or indoor air temperatures, measured by the licensee, reached 26 degrees Celsius (°C) or above at any point during the day, remainder of the day and the following day.

A complaint was received by the Director regarding uncomfortable temperatures in resident rooms on two separate floors in the home, including temperatures

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exceeding 26°C.

During inspection observations, a resident room was identified during to have a temperature exceeding 26°C by staff. No documentation was noted by the staff member relevant to the out of range temperature. Maintenance or care management was not notified by the staff member as per the home's process.

A resident described their room as too warm to be comfortable everyday, and to have no air circulation, despite staff awareness of the uncomfortable temperatures. Staff described the resident to exhibit sweating, flushing, and red rashes when their room was hot. Another resident said their room was very hot during the summer many times, stated they felt heat stress from the elevated temperatures, and staff did not fix the concern. Both residents' families purchased supplemental fans for their rooms.

A staff member reported the home used manual monitoring, where maintenance staff would test resident rooms and common areas for air temperatures, and take action when temperatures over 26°C were identified. At least ten temperature logs between May and August 2025 were identified to exceed 26°C, including a room on a specified floor. The resident occupying the room was at high risk of heat related illness. They were identified by registered staff to have a new fever at a time when their room was described as very warm. Their family purchased a supplemental fan for their room.

Within digital air temperature measurements between July and August 2025, multiple resident rooms were identified to concurrently have temperatures exceeding 26°C on seven separate dates. Nine rooms on a specific floor were involved. Daily cumulative durations of the excessive temperatures averaged over at least one hour, and occurred more frequently for specific resident rooms on the

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floor. In August, one of the rooms was noted to have temperatures above 26°C for a continuous period of 10 hours. At the time of inspection, the home did not have a formal process in place for monitoring or reviewing the digital temperature logs.

At least thirteen maintenance requests involving concerns of excessive heat in resident rooms and common areas were logged between June and August of 2025, including three separate floors in the home. Seven of the requests were related to a specific floor, including multiple requests for two specific resident rooms. At the time of inspection, records of investigation and corrective action were available for response to one resident request on a specific floor. Environmental service staff stated they would have expected records were maintained of investigation and what corrective actions were taken for resident concerns of excessive heat.

No supplemental cooling equipment was made available on site by the licensee for direct care staff to implement when needed.

Failure to ensure that air conditioning was operating in resident rooms when needed affected the quality of life for multiple residents, and placed them at increased risk of heat related illness.

Sources: Inspector observations; Records including air temperature logs; Interviews with residents and staff

This order must be complied with by November 27, 2025

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

Central West District

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

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
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.