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

**Central East District**
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Oshawa, ON, L1H 1A1
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# Public Report

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| **Report Issue Date:** October 15, 2025 |
| **Inspection Number:** 2025-1323-0004 |
| **Inspection Type:**<br>Complaint |
| **Licensee:** Extendicare (Canada) Inc. |
| **Long Term Care Home and City:** Extendicare Kawartha Lakes, Lindsay |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24-26, and October 1-3, 6-10, 2025

The inspection occurred offsite on the following date(s): September 29 and October 14, 2025

The following intake(s) were inspected:
An intake related to an anonymous complaint with an allegation regarding inadequate meals for residents.

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Reporting and Complaints

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 16.**
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of

residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure that the residents' rights to proper accommodation, nutrition, care and services consistent with their needs were fully respected and promoted.

The Executive Director (ED) received an email from a staff member outlining multiple concerns from residents, family members, and staff about the previous evening's dinner meal.

The email described that there was only one meal option available and that there was not enough texture modified foods. It further stated that portion sizes were inadequate. Several residents reportedly left the dining room hungry.

Family members reported that residents that required special diets did not receive them, and instead were provided meal options that were unsuitable for them.

A resident became emotional and stated that they were very upset with their meal that day and that they went to bed hungry.

**Sources:** Email correspondence between a staff member and ED, Photograph of meals served, interviews with family members and a resident.

## WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)**
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

The licensee failed to ensure that every alleged, suspected or witnessed incident of

neglect of a resident by the licensee or staff was immediately investigated.

The ED received an email from a staff member outlining multiple concerns from residents, family members, and staff about the previous evening's dinner meal. The email included that meal portion sizes were inadequate and several residents reportedly left the dining room hungry.

These concerns, which indicated residents' basic nutritional needs may not have been met, constituted suspected neglect of multiple residents.

The ED confirmed that the allegation of suspected neglect was not investigated immediately, and acknowledged that suspected neglect of residents should have been investigated immediately.

**Sources:** Email correspondence between staff and ED, interview with ED.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 licensee failed to ensure that the Director was immediately informed of an incident of suspected neglect of multiple residents.

The ED received an email from a staff member outlining multiple concerns from residents, family members, and staff about the previous evening's dinner meal. The email included that meal portion sizes were inadequate and several residents reportedly left the dining room hungry.

These concerns, which indicated residents' basic nutritional needs may not have been met, constituted suspected neglect of multiple residents.

The ED confirmed that this information was not reported immediately to the Director, and acknowledged that the suspected neglect of residents should have been reported immediately, as required under the Act.

**Sources:** Email correspondence between staff member and ED, interview with ED.

## WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)**
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

1) The licensee failed to implement the home's policies related to written diets and supplement orders when the home's registered dietitians (RD) did not place a written order upon initiating or discontinuing nutritional supplements and diets.

**Sources:** resident's clinical records, interview with staff, home's policies.

2) The licensee failed to implement the home's policy related to menus for emergency situations when there was inadequate food supply to prepare the planned menu items.

On a specified date, the ED purchased takeout dinners for all residents because the contingency menu offered to the resident was both unsafe and insufficient to meet the residents' nutritional needs.

**Sources:** Home's Spring/Summer menu cycle, interviews with staff and family members, home's policies.

## WRITTEN NOTIFICATION: Menu planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 77 (5)**
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that planned menu items were offered and available at each meal.

The posted daily menu offered a hot meal option at lunch. A photograph of the same day's meal showed that residents received a different item.

District Manager of Food Services indicated that the meal that was served did not accurately reflect what was indicated on the menu for that day.

**Sources:** Photographs of posted menu and meals, interview with District Manager of Food Services.

## WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 77 (6)**
Menu planning
s. 77 (6) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a menu was developed for a resident who required an individualized diet to manage a medical condition.

Staff were using a version of the regular diet menu that highlighted items suitable for the individualized diet at the point of service. However, this menu had not been approved by the home's RDs nor reviewed with the resident's substitute decision-maker (SDM).

**Sources:** resident's clinical records, interview with staff and family members, home's complaint records, home's policies.

## WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 77 (8)**
Menu planning
s. 77 (8) The licensee shall ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that food and beverages that were appropriate for the residents' diets were accessible to staff and available to residents on a 24-hour basis.

Several staff members reported that for more than two months, there had been an insufficient supply of appropriate foods for all residents, including those with special dietary needs, texture-modified diets, and nutritional supplements.

On a specific date, a specific food item was unavailable for the residents. During an observation of the food items accessible in the serving areas, it was noted that half of the items required to be available 24 hours a day were out of stock.

**Sources:** observations, anonymous complaint, interviews with staff, home's policies.

## WRITTEN NOTIFICATION: Food production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)**
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

The licensee has failed to ensure that preparation of all menu items were according to the planned menu.

The posted daily menu, which was a contingency menu, offered a specific cold plate choice for the dinner meal. The original planned menu for the same day was supposed to include a hot dinner choice. A photograph of the same day's meal showed that

residents received takeout for the dinner meal, however the menu was not updated to reflect this.

Staff from different departments confirmed that the menu items were not prepared according to the planned menu, and that the contingency menu items weren't served due to food safety concerns.

**Sources:** Photographs of posted menu and meals served, kitchen dinner meal production sheets, interviews with staff.

## WRITTEN NOTIFICATION: Food production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)**
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that menu substitutions were communicated to residents and staff.

The posted daily menu, which was a contingency menu, offered a specific cold plate choice for the dinner meal. The original planned menu for the same day was supposed to include a hot dinner choice. A photograph of the same day's meal showed that residents received takeout for the dinner meal, however the menu was not updated to reflect this.

On a separate day, kitchen production sheets and the menu substitution form for the same day indicated that a menu substitution was made, however the menu was not updated to reflect this.

**Sources:** Photographs of posted menu and meals served, menu substitution form, kitchen production report.

## WRITTEN NOTIFICATION: Food production

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

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)**
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

The licensee has failed to ensure that menu substitutions were documented on the production sheet.

The posted daily menu, which was a contingency menu, offered a cold plate choice for the dinner meal. A photograph of the same day's meal showed that residents received takeout for the dinner meal.

The kitchen production sheets for the same day indicated the the original planned menu for the same day, which was supposed to include a hot plate choice. The kitchen production sheets were not updated to reflect the menu change and did not include the meal items that were served.

**Sources:** Photographs of posted menu and meals served, kitchen dinner meal production sheets.

## WRITTEN NOTIFICATION: Food production

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)**
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to prevent adulteration and contamination of food during a lunch meal service. A staff member was seen using their bare hands to handle food for several residents. There were no tongs available at the serving station for food handling.

The staff member stated that this practice was common in the home and that they were

unaware it was inappropriate. The Director of Care (DOC) indicated that staff should not have direct contact with residents' food and must use tongs or other utensils when assisting with meal service.

**Sources:** lunch meal observation, interviews with staff.

## WRITTEN NOTIFICATION: Food production

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (4) (c)**
Food production
s. 78 (4) The licensee shall maintain, and keep for at least one year, a record of,
(c) menu substitutions. O. Reg. 246/22, s. 78 (4).

The licensee has failed to ensure that a record of menu substitutions was maintained and kept for at least one year.

The posted daily menu, which was a contingency menu, offered a cold plate option for the dinner meal. The original planned menu for the same day was supposed to include a hot plate option. A photograph of the same day's meal showed that residents received takeout for the dinner meal.

Dietary staff indicated that menu substitutions sheets were not available for staff to fill out and were therefore not documented. District Manager of Food Services confirmed that confirmed that menu substitutions were not documented since May 2025.

**Sources:** Photographs of posted menu and meals served on, kitchen dinner meal production sheets, interviews with staff.

## WRITTEN NOTIFICATION: Food production

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)**
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O.

Reg. 246/22, s. 78 (7).

The licensee has failed to ensure staff of the home comply with the cleaning schedule for all the equipment.

Observations of the main kitchen revealed ice build up and debris inside the main walk-in freezer. Observations of serveries in both Resident Home Areas (RHA)s showed the refrigerator, its handle, cabinet handles, countertops, and floor appeared dirty, sticky, and had visible food debris.

A Compliance Inspection Report from the Haliburton, Kawartha, Pine Ridge District Health Unit also documented instances of equipment including the food processor machine, nutribullet, walk-in freezer, juice dispenser and ceiling tiles and walls in the kitchen not being clean.

Cleaning schedules for the main kitchen indicated several gaps where multiple shifts did not sign off on cleaning duties for equipment and the walk-in fridge and freezer.

Interviews with Food Service Worker staff indicated that they often do not have time during their shifts to clean equipment and servery areas according to the cleaning schedule.

**Sources:** Observations of the main kitchen, Haliburton, Kawartha, Pine Ridge District Health Unit Compliance Inspection Report, interviews with staff.

## COMPLIANCE ORDER CO #001 Duty to protect

NC #014 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 ensure the following:

1) The Regional Director of Operations or delegate will provide in person education to the leadership management team, including all department heads and the Food Service District Manager, on the home's policies related to Zero Tolerance of Abuse and Neglect Program and Immediate Response and Mandatory Reporting of Abuse and Neglect. Keep a documented record of the date the education was provided, the content of the education and the signatures of the leadership management team and the Regional Director to confirm the education was provided.

2) Develop and implement a written process to identify, monitor and mitigate risk related to residents not receiving meals and snacks consistent with their diet orders. This process should also address potential shortages or staffing issues that may lead to insufficient food availability and meal preparation.

3) Develop, implement and administer a resident satisfaction survey to obtain feedback on the quality, portion size, choice, temperature and overall satisfaction with meals and snacks provided in the home. Ensure that the survey is accessible to all residents, and allow family members or substitute decision-makers to participate on behalf of residents who are unable to respond independently. Analyze the survey results to identify common themes, concerns and areas for improvement. Develop and implement an action plan to address any issues identified through the survey. Maintain documentation of the survey responses, analysis and corrective actions taken.

**Grounds**

An anonymous complaint was submitted to the Director, stating that the home's dietary department was not providing sufficient food to meet legislative requirements. An email was sent to the ED and the DOC reporting that residents were served a cold plate for dinner without alternatives or pureed options. Many residents reported feeling upset and hungry.

On another day, the ED purchased takeout meals for all residents because the menu items available were unsafe and unsuitable for texture-modified diets. A resident's SDM indicated that they were unsure whether they received their required diet.

Record reviews revealed that menu substitutions had not been documented for four months, which was necessary to ensure that the alternatives provided similar nutritional

value to the planned meals. A resident experienced an adverse health event due to inappropriate dietary interventions.

The complaint binder for the home indicated that several complaints regarding the unavailability of food for the regular menu, specialized diets and snacks. Cooks indicated not having the proper food to prepare the menu items, which was also reported to the management team.

Meal observations revealed that texture-modified diets were not prepared according to the home's guidelines, and cold menu items were not served at safe temperatures.

Interviews with staff, residents, and family members confirmed that the home often lacked the necessary foods to prepare the planned menu items, including those for residents with special dietary needs and nutritional supplements. Specifically, a resident reported feeling upset and became emotional when asked about their feelings regarding being served a cold menu item without entree and alternative choices.

On another occasion, a specific food item was not available in the home, and the nursing staff had to contact the DOC to purchase the food item. Additionally, when a hot meal was listed on the menu, no pureed entrée was prepared. Cooks reported that did not have the proper food to prepare the menu items, which was also reported to the management team.

Both the DOC and ED acknowledged that neglect occurred when food was unavailable for the residents.

The following non-compliance was identified within this report specific to the residents' nutritional care:

- CO - O. Reg 246/22, s.79 (1) 5 - The licensee failed to ensure foods and fluids were served at a temperature that were both safe and palatable to residents.

- CO - O. Reg 246/22, s. 74 (2) (c) – The licensee failed to implement interventions to mitigate nutritional risks for residents who required special dietary interventions.

- CO - O. Reg 246/22, s. 108 The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the nutritional care of a

resident or operation of the home was dealt with in accordance with the requirements of the legislation.

- WN – FLTCA, 2021, s. 28 (1) 2. The licensee failed to ensure that the Director was immediately informed of an incident of suspected neglect of multiple residents.

- WN – s. 3 (1) 16. The licensee failed to ensure that the residents' rights to proper accommodation, nutrition, care and services consistent with their needs were fully respected and promoted.

- WN - O. Reg 246/22, s. 74 (2) (a) The licensee failed to implement the home’s policies for written orders for diets and supplement as well as to implement the policy for menus for emergency situations.

- WN - O. Reg 246/22, s. 77 (5) The licensee failed to ensure that planned menu items were offered and available at each meal.

- WN - O. Reg 246/22, s. 77 (6) The licensee failed to ensure that an individualized menu was developed for a resident.

- WN - O. Reg 246/22, s. 77 (8) The licensee failed to ensure that food and beverages that were appropriate for the residents’ diets were accessible to staff and available to residents on a 24-hour basis.

A series of failures and omissions lead to the neglect of residents to ensure they were provided with adequate nutrition required to ensure their health, safety and comfort during a four-month period in their home. The failure of managers to oversee and ensure their policies, programs and the legislation were implemented and complied with were neglectful and impacted the quality of life of the residents.

**Sources:** anonymous complaint, residents' clinical health records, and interviews with staff as detailed in the separate findings of this report.

**This order must be complied with by** January 15, 2026

## COMPLIANCE ORDER CO #002 Nutritional care and hydration programs

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)**
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

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

The licensee shall ensure the following:

1) Complete a review of the home's menu cycle and standardized recipes to ensure all minced, pureed, and thickened fluids meet the requirement outlined in the home's guidelines for therapeutic diets, texture and liquid modifications. Maintain a log of any texture modified foods which were identified that did not meet the requirements in the home's diet texture policy for four weeks. Include the food/menu item name, the meal when the food was planned to be served (e.g., week one, specific date of the week, lunch), the date when the issue was identified, who identified the issue, and any corrective actions taken to fix the issue.

2) Corporate Chef to provide in-person training to the cooks and dietary staff on the proper preparation and service of pureed and minced textures. Keep a record of training sessions, including the date, content, trainer’s name, and attendees.

3) Update the home’s guidelines for therapeutic diets, texture and liquid modifications policy to include safe storage, preparation, and service of the gluten restricted diet. Provide in-person training to all cooks and dietary staff, including any staff cross-trained to work as dietary staff. Keep a record of training sessions, including the date, the content, trainer’s name, and attendees.

4) Registered Dietitian to complete a nutritional assessment of residents to ensure that their specialized menus meet their specific requirements. Ensure that the residents’ SDMs are involved in the revision of the menu and implementation of the interventions.

5) Ensure that the written diet and supplement orders meet the home’s guidelines for

therapeutic diets, texture and liquid modifications for all residents and that they are consistent across the care plans, Meal Suite and diet lists.

**Grounds**

1) The licensee failed to implement interventions to mitigate risks for a resident who required a special diet to manage a medical condition when they were given the wrong intervention, causing an adverse health event.

The resident's SDM did not know who was responsible for ensuring the appropriate diet was provided. Cooks and a Dietary Aides (DA) had not been trained on the safe storage, preparation and service of a specialized diet. Failure to provide the resident with a specialized diet resulted in an adverse health event and increased nutritional risk.

**Sources:** snack observation, resident's clinical records, interviews with staff and family members, and home's policies.

2) The licensee has failed to ensure that a resident received a nutritional intervention required for their food intolerance.

On a specified date, the RD approved a nutritional intervention for a resident without completing a nutritional assessment. Clinical records showed that the resident received an inappropriate intervention for a prolonged period.

**Sources:** resident’s clinical records, interview with staff and family members.

3) The licensee failed to implement interventions to mitigate risks for residents requiring texture modified diets.

During meal observations, pureed and minced items were not cohesive and showed water separation. The minced entrées appeared dry and lumpy, while pureed items looked thick and chunky, unsuitable for residents on texture-modified diets due to choking risks.

Cooks reported that they had not received training on preparing texture-modified diets.

Failure to prepare and serve texture-modified diets according to the residents' needs

increased the risk of choking and adverse health events.

**Sources:** meal observations, residents' clinical records, interviews with staff, email correspondence from consulting Dietitian, home's policies.

**This order must be complied with by** January 15, 2025

## COMPLIANCE ORDER CO #003 Dining and snack service

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.**
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

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

The licensee shall ensure the following:

1) The District Manager of Food Services or their designate will provide in-person training to all cooks and dietary staff, including any staff cross-trained to work as dietary staff on the following:

a) Taking and recording end-point cooking and point-of-service temperatures, including the date, meal type, and corrective actions taken.
b) Tray assembly and service according to the home's policy.
c) Keep a record of training sessions, including the date, the content, trainer's name, and attendees.

2) The Dietary Manager or designate will conduct three meal service audits per week for four weeks on the home's serveries:

a) Temperatures being taken at end-point-cooking and point of service. The audits should capture different meal service times and dining areas, person completing the

audit, foods being served, any missing recorded temperatures, any food temperatures outside the range defined by the home's Holding Food and Distribution of Food and Temperatures of Food at Point of Service Policies and any corrective actions taken.

b) Weekly, the Dietary Manager will analyze the audit results and provide further corrective actions to staff based on observed trends. A documented record of audits will be kept and made available upon request.

**Grounds**

The licensee failed to ensure foods and fluids were served at a temperature that were both safe and palatable to residents.

Observations during meal service, revealed that cold menu items were kept and served at temperatures exceeding four degrees Celsius (4°C). No corrective actions were taken by the dietary staff. The District Manager of Food Services reported that the ice machine had been out of order for three days and acknowledged they had forgotten to purchase ice. Confirmed that cold items should have been kept below 4°C.

During tray service for two residents, it was observed that menu items were not covered. A staff member noted that drinks were typically covered with plastic wrap, but it wasn’t done during that meal service.

Failure to serve residents' food at safe temperatures increased the risk of foodborne illnesses and could negatively affect the palatability of the food for the residents.

**Sources**: observation of lunch meal service, interviews with staff, and home's policies.

**This order must be complied with by** January 15, 2026

## COMPLIANCE ORDER CO #004 Dealing with complaints

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 108**
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.

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.

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

ii. an explanation of,

A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

(2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

(3) The licensee shall ensure that,

(a) the documented record is reviewed and analyzed for trends at least quarterly;

(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and

(c) a written record is kept of each review and of the improvements made in response.

(4) Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received.
(5) Where a licensee is required to immediately forward a complaint under clause 26 (1) (c) of the Act, it shall forward it in a form and manner acceptable to the Director, and,
(a) during the Ministry's normal business hours, to the Director or the Director's delegate; or
(b) outside normal business hours, using the Ministry's after hours emergency contact method.

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

The licensee shall ensure the following:

1) The Regional Director or delegate will provide education to the leadership management team, including all department heads and the Food Service District Manager, on the complaint process within the home, the home's policies related to complaints and legislative requirements. Keep a documented record of the date the education was provided, the content of the education and the signatures of the leadership management team and the Regional Director to confirm the education was provided.

**Grounds**

The licensee has failed to 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 was dealt with in accordance with the requirements of the legislation.

An email was sent to the ED outlining several concerns regarding the previous evening's dinner meal. The email described that several residents, staff and family members raised complaints about the portion size of the meal, and that many residents left the dining room feeling hungry.

ED confirmed that the written complaint was not investigated and not resolved within 10 business days. A documented record was of the complaint was not kept in the home. The complainant did not receive a response outlining what the licensee had done to resolve the complaint or the with Ministry's toll-free telephone number. The complaint

was not analyzed for trends.

Failure by management to investigate, document and respond to complaints prevented issues affecting residents' care and satisfaction from being identified and addressed in a timely manner, and impeded the home's ability to identify patterns or systemic issues related to food service quality.

**Sources:** Email correspondence between complainant and ED, interview with ED.

**This order must be complied with by** December 15, 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.