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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: September 18, 2025
Inspection Number: 2025-1498-0005
Inspection Type:
Complaint
Critical Incident

Licensee: Royal Canadian Legion District 'D' Care Centres
Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9 to 12, and 15 to 18, 2025.

The inspection occurred offsite on the following date(s): September 15, 2025.

The following intake(s) were inspected:
- A complaint related to food temperature, laundry services, outdoor spaces, and continence care

- A complaint related to resident care

- A Critical Incident Report (CIR) related to the alleged neglect of a resident

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 the plan of care was provided to a resident as specified in the plan when it was observed that an identified intervention was not in place for falls prevention. Staff confirmed that the resident required an identified intervention for falls prevention and indicated that the intervention was not provided to the resident as specified in the resident's plan of care.

Sources: A resident's clinical records, Observations, Interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care for a resident were documented. An intervention was initiated where registered staff were required to document their care and care outcome every shift in the electronic health record system. When reviewed, there were multiple shifts where the documentations were not completed as required.

Sources: CIR, a resident's electronic health record system, and staff interview

WRITTEN NOTIFICATION: Laundry Services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;

The licensee has failed to ensure that as a part of the organized program for laundry services under clause 19 (1) (b) of the Act, that the long-term care home ensured a procedure was developed and implemented to meet a resident's personal clothing laundry needs.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that a written policy was developed for residents personal clothing laundry program and was complied with.

During observations it was noted residents personal clothing was sent out to be laundered by the third-party vendor. A policy for third party vendor, laundering residents personal clothing was not in place.

An interview with staff indicated all resident personal clothing was laundered to a third-party vendor and that they were not familiar with any policy. Further interviews staff confirmed the home did not have a policy in place for residents' personal laundry being laundered by a third-party vendor.

Sources: A resident's complaint, the home's policy review, observations, interviews with staff

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 12.
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:
12. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Home is to produce a policy to the accessibility of the protected outdoor garden space. The policy should include information related to Resident's Bill of Rights, accessibility, safety measures, program activities, staff responsibilities, and staff guidance to encourage and support resident use of the protected outdoor garden space.

2) The home is to provide education on the policy to all staff in the home and education records are to be available upon request by the MLTC.

Grounds
The licensee has failed to ensure that residents where given access to a protected outdoor area.

Through observations it was noted that the outdoor main gazebo was utilized by smokers in the home, the garden located outside the atrium was observed to be locked and not utilized by residents. Through observations of the outdoor garden, the left side garden door was not secure as it was closed with a metal rod which could be pulled out giving access to the external grounds of the home.

Interviews with staff indicated the locked outdoor garden area required resident supervision. The outdoor garden was accessible to residents only if program staff was in the building, available, or the nursing staff had time to take the resident out to the garden.

Sources: A resident's complaint, observations, interview with a resident and staff

This order must be complied with by November 14, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.