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 26, 2025

Inspection Number: 2025-1157-0007

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Tendercare Nursing Homes Limited

Long Term Care Home and City: Tendercare Living Centre, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 8-12, 15-19, and 22-26, 2025
The following intake(s) were inspected:
-An intake related to the first follow up of Compliance Order (CO) #002, from inspection #: 2025-1157-0005, related to O. Reg. 246/22 s. 79 (1) 4. Dining and snack service, with a Compliance Due Date (CDD) of September 4, 2025.
-An intake related to the first follow up of CO #003, from inspection #: 2025-1157-0005, related to O. Reg. 246/22 s. 261 (2) 1. Additional training - direct care staff, with a CDD of September 4, 2025.
-An intake related to the first follow up of CO #001, from inspection #: 2025-1157-0005, related to O. Reg. 246/22 s. 54 (1) Falls prevention and management, with a CDD of September 4, 2025.
-An intake related to the fall of a resident with injury
-An intake related to a complaint regarding resident care and the operation of the home
-An intake related to a resident to resident interaction
-An intake related to a resident injury of unknown cause
-An intake related to a complaint regarding falls prevention and management for a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2025-1157-0005 related to O. Reg. 246/22, s. 261 (2) 1.
Order #001 from Inspection #2025-1157-0005 related to O. Reg. 246/22, s. 54 (1)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #002 from Inspection #2025-1157-0005 related to O. Reg. 246/22, s. 79 (1) 4.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
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 (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; and

The licensee failed to ensure that the nursing staff collaborated with the interdisciplinary team in relation to the assessment of a resident's pain to ensure that their assessments

were integrated and were consistent with and complemented each other. The resident reported they were experiencing pain on a specified date. A diagnostic test was ordered but was not completed until a specified date. The resident's clinical records indicated they continued to report pain during the specified time period and that there were no referrals made to other members of the interdisciplinary team for further assessment of the underlying cause of the pain.

Sources: Clinical records for a resident, the home's Pain Management Policy, and interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect was complied with. The home's Zero Tolerance of Abuse and Neglect Program Policy outlined that interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected will be followed as per the Interventions and Support for Recipients of Alleged Abuse or Neglect Procedure. The Interventions and Support for Recipients of Alleged Abuse or Neglect Procedure detailed that the Executive Director (ED) or DOC/Wellness/Incident Manager is responsible to ensure that the alleged abuse recipient is provided support through the completion of full assessments to determine resident needs and physical and emotional well-being. A resident experienced an incident and an assessment was initiated, however, was not fully completed, as required intervals were missed. A staff member acknowledged that not all of the expected intervals were completed.

Sources: Clinical records for a resident, the home's policies and procedures, and interviews with staff.

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director, a written complaint that the home received concerning the care of a resident.

The resident's Substitute Decision Maker (SDM) sent an electronic mail (E-mail) to the home inquiring about the resident's fall incident. The SDM sent another follow up E-mail, expressing concerns regarding the care of the resident.

A staff member acknowledged that the SDM's E-mail was supposed to be forwarded to the Director as it contained concerns regarding the care of the resident.

Sources: E-mail communication between the SDM and the home, and interviews with staff.

WRITTEN NOTIFICATION: Conditions of licence

NC #004 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.

Compliance Order (CO) #002 from inspection #2025-1157-0005 issued on June 9, 2025, with a Compliance Due Date (CDD) of September 4, 2025, to O. Reg. 246/22, s. 79 (1) 4. was not complied with.

The following components of the order were not complied:

2. The Dietary Service Manager, DOC or designate shall provide training to all staff participating in dining room services on the written process.

The licensee has failed to ensure that all staff participating in dining room services received training on the written process. A staff member acknowledged that there were gaps in ensuring that all staff that participate in the dining room services received the training, noting that not all required staff may have received the training. The home's documentation related to the training demonstrated that not all staff participating in the dining room services were documented as receiving the training.

Sources: The home’s staff education sign in sheets, the home’s list of staff, and interviews with staff.

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 #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is 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:
In the past 36 months, a CO was issued to O. Reg. 246/22, s. 79 (1) 4. as part of inspection #: 2025-1157-0005.

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: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home's resident-staff communication and response system was accessible to a resident on a specific date. The resident was unsupervised in their room and the call bell was inaccessible to the resident. A staff member acknowledged that the call bell was not within the resident's reach.

Sources: Observation, clinical records for a resident, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1. The licensee failed to ensure that staff used safe transferring techniques when they assisted a resident.

According to the evidence provided to the Inspector, a staff member failed to apply the required interventions for the resident's assistive device. The resident had a fall and sustained injuries.

Sources: The resident's clinical records, the home's investigation notes, and multiple staff interviews.

2. The licensee failed to ensure that staff utilized safe transferring and positioning techniques when assisting a resident on a certain date. The resident's plan of care outlined specific instructions for staff related to transferring and continence care. A staff member reported that the staff assisted the resident to transfer and with their continence care, however, the instructions were not followed as outlined in the resident's plan of care.

Sources: Clinical records for a resident and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure a resident's post-fall assessment contained accurate and complete information.

The home's Fall prevention policy indicated a post-fall incident assessment must be completed by a nurse and shall include a review of the events leading up to the fall, an analysis of contributing factors, and determination of the probable root cause. This was not completed in its entirety for the resident.

Sources: The home's Fall prevention policy, the resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

1. The licensee failed to ensure that actions were taken to respond to the needs of a resident, including assessments. A resident demonstrated responsive behaviours on a specified date. A specific type of assessment was implemented to monitor the resident's behaviours. The assessment was incomplete, as not all of the required intervals of the assessment form were completed. A staff member confirmed that the expectation for the assessment tool is for all intervals to be completed and acknowledged that it was not fully completed.

Sources: Clinical records for a resident and interview with staff.

2. The licensee failed to ensure that actions were taken to respond to the needs of a resident, including assessments. A resident demonstrated responsive behaviours on a specified date. An assessment was implemented to monitor the resident's behaviours. The assessment was incomplete, as not all of the required intervals of the assessment form were completed. A staff member acknowledged that the assessment was initiated for the resident, however, not all intervals were completed.

Sources: Clinical records for a resident and interview with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #009 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;

The licensee has failed to ensure that their written policy related to their dietary services was complied with.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols were developed for the nutritional care and dietary services and ensure they were complied with.

Specifically, staff did not comply with the home's policy, when the staff failed to confirm the identity of residents before serving the meal to them. The Dietary Services Manager (DSM) stated that it appeared that staff are not following the home's protocols.

Sources: Observations, the home's policy, and interview with the DSM.

WRITTEN NOTIFICATION: Dietary services

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 76 (d)
Dietary services
s. 76. Every licensee of a long-term care home shall ensure that the dietary services component of the nutritional care and dietary services program includes,
(d) availability of supplies and equipment for food production and dining and snack service.

The licensee failed to ensure that they had adequate supplies and equipment for dining service.

During an observation, staff on a specified Resident Home Area (RHA) were seen collecting used mugs and cups in a plastic bag hung in the middle of the hallway. These items were then taken to the dining room during lunch service for cleaning. It was also noted that staff did not have an adequate supply of mugs required to pour beverages for residents' trays. The Infection Prevention and Control (IPAC) Lead confirmed that this practice was due to a shortage of mugs and cups within the home.

Sources: Observations and interviews with the IPAC Lead and DSM.

WRITTEN NOTIFICATION: Menu planning

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (c)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes a choice of beverages at all meals and snacks;

The licensee failed to ensure residents were offered a choice of beverages at all meals.

During an observation of the dining room, it was noted that beverages were served to residents without first inquiring about their individual preferences. It was further observed that drinks had been pre-poured and placed on tables prior to the residents' arrival. The DSM confirmed that staff did not follow the home's policy and confirmed that beverages should not have been pre-poured prior to residents arriving in the dining room.

Sources: Observations, review of the home's policy, and interview with the DSM.

WRITTEN NOTIFICATION: Dining and snack service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required assistance with eating and drinking was not served a meal until someone was available to provide the assistance required.

A resident was observed seated at a table in the dining area with their meal placed in front of them on the table. Throughout the observation period, no staff members were observed providing assistance to the resident with their meal. According to the resident's care plan, staff are to assist the resident with meals.

Sources: Observation and clinical records for a resident.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

During observations staff were seen collecting used cups and mugs after morning snack by placing them in a plastic bag that was hung in the middle of the hallway, within reach of residents. The IPAC Lead acknowledged that placing used mugs and cups in a plastic bag hung in the middle of the hallway is an unsafe practice and not aligned with the guidance provided to staff, as it posed a risk of cross-contamination.

Sources: Observations and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Dealing with complaints

NC #014 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 failed to ensure that when they received a written complaint concerning the care of a resident, a response was provided to the complainant within 10 business days of the receipt of the complaint.

The resident's SDM sent an E-mail to the home inquiring about the resident's fall incident and sent another follow up E-mail expressing concerns regarding the care of the resident.

The home sent their response E-mail to the complainant with the result of their investigation, however, it was beyond the 10 business days time frame.

Sources: E-mail communication between the SDM and the home and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
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):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed of a resident's fall incident, which resulted in a significant change in their health status.

The resident had a fall, sustained multiple injuries, and required to be transferred to the hospital. Upon their return from the hospital, the resident required further monitoring and treatments due to the injuries.

Sources: The resident's clinical records and interviews with staff.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Director of Care (DOC) and the designated interim Skin and Wound Lead will analyze, review and if necessary, revise the home's Skin and Wound Policy to ensure it reflects the current process in the home. As part of this review/revision the home will ensure that the policy includes a clear process and clinical pathway for registered staff that is guided by current evidence-based practices. Keep a documented record of the analysis and revisions, revised policy and procedure, and provide it to the Inspector upon request.

2. The DOC and the designated interim Skin and Wound Lead will provide education to all registered staff, including agency and casual staff, working on the specified Resident Home Areas (RHAs) regarding section one of this Compliance Order (CO).

a) The education may be provided in person or virtual.
b) The home shall produce a list of required staff to complete the education upon receiving this CO and provide it to the Inspector upon follow-up inspection.
c) Education documentation must include: date and content of the session, full names and designations of educators and participants, confirmation that each required participant completed the education (e.g., attendance records, completion acknowledgement, or digital sign-offs). The documentation must be retained and provided to the Inspector upon request.

3. The DOC and/or the designated interim Skin and Wound Lead will conduct weekly audits for three consecutive weeks of all residents identified as having altered skin integrities to ensure the initial and weekly skin assessments contain accurate and

precise documentation including but not limited to measurements, treatments, referrals to appropriate interdisciplinary team members (if applicable), and a final weekly assessment if the skin impairment is resolved/healed.

a) A list of residents identified with altered skin integrities must be produced upon receiving this CO, and the audit will be conducted on the residents identified.
b) Documentation of the audits will include the date of the audit, the name and designation of the auditor, the name of the residents identified as having altered skin integrity, and any corrective actions when the home’s process not followed. This documentation must be retained and provided to the Inspector upon request.

Grounds

1. The licensee failed to ensure that skin assessments for a resident, contained accurate and complete documentation and were done on a weekly basis.

The resident sustained multiple altered skin integrities after a fall incident, however such injuries were not documented accurately due to missing locations, measurements, treatments being applied (if any), and repeated error in recording the location of one of the skin impairments. Weekly skin assessments for the injuries did not contain all the required information. There was no further weekly skin assessments completed after a specific date and it remained unclear whether one of the injuries was resolved. The home's skin and wound policy indicated that weekly skin assessments were to be completed in their entirety.

There was a risk to the resident's well-being when staff failed to conduct appropriate documentation and assessments.

Sources: The home's skin and wound policy, the resident's clinical records, and interview with a staff member.

2. The licensee failed to ensure that the identified altered skin integrity concerns for a resident were reassessed on a weekly basis. A resident was identified as having altered skin integrity concerns, which were initially assessed on a specified date. Head to Toe Skin Assessments were documented for a specified time period, however, there were no subsequent weekly re-assessments completed. There was no documentation indicating that the altered skin integrity concerns had resolved/healed. A staff member

acknowledged that there were no weekly follow up assessments completed for the specific skin integrity concerns. Failure to complete the follow up skin and wound assessments resulted in lost opportunity for monitoring of the skin integrity concerns, which placed the resident at increased risk of negative clinical outcomes.

Sources: Clinical records for a resident and interview with a staff member.

3. The licensee failed to ensure that the identified altered skin integrity concerns for a resident were reassessed on a weekly basis. A resident was identified as having altered skin integrity concerns, which were initially assessed on a specified date. Head to Toe Skin Assessments were documented for a specified time period, however, there were no subsequent weekly re-assessments completed. There was no documentation indicating that the altered skin integrity concerns had resolved/healed. A staff member acknowledged that the weekly reassessments for the resident were not completed. Failure to complete the follow up skin and wound assessments resulted in lost opportunity for monitoring of the skin integrity concerns, which placed the resident at increased risk of negative clinical outcomes.

Sources: Clinical records for a resident and interview with a staff member.

This order must be complied with by December 19, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1)The IPAC lead and/or a member of the clinical management team is to educate all nursing staff (including registered staff and unregulated health care providers) that work on the specified Resident Home Areas (RHAs), on mask-wearing protocols as required

by the facility. Staff must receive training on the correct use of masks, including proper donning techniques to ensure effective infection prevention and control. Guidance should also be provided on when and where masks must be worn, specifically, whether it should be worn before entering an outbreak unit.
2) The home shall produce a list of required staff to complete the education upon receiving this Compliance Order (CO) and provide it to the Inspector upon follow-up inspection.
3) Education documentation must include: date and content of the session, full names and designations of educators and participants, confirmation that each required participant completed the education (e.g., attendance records, completion acknowledgement, or digital sign-offs). This documentation must be retained and provided to the Inspector upon request.
4)The IPAC lead and/or designate will conduct daily audits for three consecutive weeks to ensure nursing staff are properly donning and doffing PPE. Audits should rotate across all three shifts to capture all residents on additional precautions.
5)The home shall produce a list of residents on additional precautions upon receiving this CO and provide it to the Inspector upon follow-up inspection.
6)Audit documentation must include on-the-spot education and remedial actions when non-compliance identified and learning plan for staff identified to have repetitive non-compliances. The documentation of the audits must include the date and time of the audit, the home area, the resident’s name and room number, the auditor’s name and signature, the full name and position of the staff’s being audited. Provide the documented records to the Inspector upon request.

Grounds

1. The licensee has failed to ensure that the Standard issued by the Director related to Infection Prevention and Control (IPAC) was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with related to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 9.1 (f) indicated additional PPE requirements including appropriate selection application, removal, and disposal.

A staff member did not wear the required Personal Protective Equipment (PPE) when

providing care to a resident in bed, who was on isolation. The staff member and the Infection Prevention and Control (IPAC) Lead confirmed that they should have donned the required PPE.

Failure to wear the required PPE placed the residents at risk of further spread of the infection.

Sources: Inspector observations and interviews with staff.

2. The licensee has failed to ensure that the Standard issued by the Director related to Infection Prevention and Control (IPAC) was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with related to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCH), dated April 2022, revised September 2023, section 6.7 indicated that all staff, students, volunteers and support workers comply with applicable masking requirements at all times.

During an observation, It was observed that a staff member did not wear a mask before entering an outbreak unit. Although the home had active screening measures in place and clear signage throughout the outbreak unit indicating that masks were required, staff failed to comply with mask-wearing protocols.

During a facility-wide outbreak, multiple staff members were observed not wearing masks in accordance with the home's policy.

Improper use of PPE poses a risk of further infection spread, particularly during an active outbreak.

Sources: Observations and Interview with the IPAC Lead.

This order must be complied with by December 19, 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.