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

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Original Public Report

Report Issue Date: April 19, 2024	
Inspection Number: 2024-1301-0002	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Glebe Centre Incorporated	
Long Term Care Home and City: Glebe Centre, Ottawa	
Lead Inspector Lisa Kluke (000725)	Inspector Digital Signature
Additional Inspector(s) Margaret Beamish (000723)	

INSPECTION SUMMARY

The inspection occurred both onsite and offsite on the following date(s): February 6-9, 12-16, 20-23, 2024, were conducted onsite and February 29 and March 7, 2024, were conducted offsite.

The following intake(s) were inspected:

- Intake: #00099878 -Follow-up #: 1 -CO#001 O. Reg. 246/22 - s. 20 (a) Communication and Response System that can be easily seen, accessed, and used by residents, staff, and visitors at all times. CDD extended January 31, 2024.
- Intake: #00099876 -Follow-up #: 1 -CO#002 O. Reg. 246/22 - s. 20 (c) Communication and Response System- that allows calls to be cancelled only at the point of activation. CDD extended to January 31, 2024.

- Intake: #00099877 -Follow-up #: 1 -CO#003 O. Reg. 246/22 - s. 20 (e) Communication and Response System- that is available in every area accessible by residents. CDD extended to January 31, 2024.
- Intake: #00097003 regarding an incident of a missing resident.
- Intake: #00097374 regarding an incident that caused unexplained bruising to a resident.
- Intakes: #00099118 and #00101576 were related to falls prevention.
- Intake: #00105955 regarding an incident of alleged resident abuse.
- Intakes: #00106826 and #00109601 were related to incidents of declared outbreaks in the home.
- Intake: #00107221 regarding a complainant with concerns related to care and services.
- Intake: #00096518 regarding a complainant with concerns related to screening process.
- Intake: #00107685 regarding a complainant with concerns about Infection, Prevention and Control (IPAC) practices.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1301-0004 related to O. Reg. 246/22, s. 20 (a) inspected by Lisa Kluke (000725)

Order #002 from Inspection #2023-1301-0004 related to O. Reg. 246/22, s. 20 (c) inspected by Lisa Kluke (000725)

Order #003 from Inspection #2023-1301-0004 related to O. Reg. 246/22, s. 20 (e) inspected by Lisa Kluke (000725)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that two specified residents were reassessed and their plan of care reviewed and revised when the residents care needs changed.

Rationale and Summary:
A-
The Director received a critical incident report regarding a resident who had a fall and was sent to hospital that resulted with an injury with a significant change in their

condition. This resident required a medical procedure that required nursing intervention upon their return to the Long-Term Care Home (LTCH), as well as changes to the resident's physical functioning status.

Upon review of this resident's plan of care after their return from hospital, the plan of care was not reviewed or revised to reflect the resident's post hospitalization care needs and assessment required.

The Director of Care and the Coordinator for Nursing Programs indicated that they could not locate any updated plan of care to reflect the changes related the resident's care needs provision after they returned from hospital post fall with injury as required.

Failing to update the resident's plan of care post fall with injury, posed a significant risk of discomfort or injury to the resident as well as the specified nursing assessment needs for post medical intervention posed a significant risk of resident deterioration or infection.

Sources: Resident health care records and interviews with Director of Care and the Coordinator of Nursing Programs.[000725]

Rationale and Summary:
B-

Another resident reported that new staff in the home did not seem to know their plan of care related to transfers and positioning needs related to their medical conditions.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated the resident's plan of care needed to be updated as the resident's transfer needs

changed.

This PSW indicated they spoke to the resident regarding their concerns for their current transfer intervention, that did not meet their increased needs.

This resident's progress notes indicated a few weeks earlier, that the resident was assessed to require increased staff assistance with a specified transfer device for all transfers and that this was communicated to the registered nursing staff on this resident's unit that day.

Failing to provide direct care staff the appropriate transfer needs can cause potential inappropriate transfer and injury to the resident.

Sources: Resident observations, interviews with a PSW, an RPN and health care record review. [000725]

WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (a)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations.

The licensee has failed to ensure that there is a written policy to minimize the

restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations.

Rationale and Summary:
The Coordinator of Nursing Programs (CNP) provided their Minimal Restraint-Physical policy via email to the inspector and indicated they were currently reviewing their policy and procedures in the home including the Restraint policy as it was out of date.

The home's Minimal Restraint-Physical policy and procedure referenced Long Term Care Homes Act 2007, and Ontario Regulation 79/10 section 109 for this policy. Fixing Long-Term Care Homes Act, 2021, and Ontario Regulation 246/22 came into force April 11, 2022, for the home to base their policy and procedures.

Failing to have current legislation reference, poses potential risks to residents for safety related to restraints use and how they are managed in the home.

Sources: Interview with the CNP and review of the home's policy and procedure for Minimal Restraint-Physical. [000725]

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.

The licensee has failed to comply with Compliance Order (CO) #003 from Inspection #2023_1301_0004 issued on October 19, 2023, with a compliance due date of January 31, 2024.

The required equipment for resident-staff communication and response system (RSCRS) was not made available in every area accessible by residents.

The required development of a process was not completed in order for the RSCRS accessibility in every area accessible by resident locations without a resident or direct care nursing staff member present wearing a device, since the RSCRS was not fixed in place in certain resident areas.

The required auditing process was not completed or documented as required.

Rationale and Summary:
The Inspector noted there was no RSCRS available in the activity room on a specified home area, two areas on the main floor, and a room in another home area.

The Manager of Building Architecture (MBA) confirmed with an inspector that their RSCRS was not in place in all areas accessible by residents, including some tub/shower rooms, patios, a courtyard, and a number of common areas in their deficiencies list. These RSCRS were partially rectified for seven of eight home areas, however a decision was made not to activate the seven resident home areas until the entire home was equipped with a RSCRS and education provided to all staff.

The MBA explained that they did not document three weekly audits alternating resident areas to ensure the RSCRS was in place and functional to activate a call for assistance as their system was not functional.

As such, the home has failed to comply with compliance order #003 regarding being equipped with an RSCRS that is available in every area accessible by residents as required. This presents a risk to residents' health, safety, and quality of life as not all residents, staff and visitors were able to access and use the RSCRS to make calls for assistance from these areas.

Sources: Observations of resident areas in the home, interviews the Manager of Building Architecture and record review. [000725]

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 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:
Previous non-compliance identified in inspection #2023_1301_0004 regarding Compliance Order (CO) #003 s. 20 (e) issued to the licensee on October 19, 2023, with two extension requests granted and a CDD on January 31, 2024.

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: 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.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023_1301_0004 issued on October 19, 2023, with a compliance due date of January 31, 2024.

The required resident-staff communication and response system (RSCRS) had not been set up so that it can be easily seen, accessed, and used by residents, staff, and visitors at all times.

The required RSCRS was not accessible in all resident care areas without a resident or direct care nursing staff member present wearing a device, since the RSCRS was not fixed in place in certain resident care areas.

The required information of the RSCRS availability in all areas accessible, was not

shared with all staff, residents and visitors.

The required auditing process was not developed or completed including documentation of these audits and all corrective actions and outcomes related to these audits.

Rationale and Summary:
The Manager of Building Architecture (MBA) indicated they initiated hard wiring into their RSCRS with connection to the Tenera RSCRS devices. This was to suffice the need for the RSCRS to be easily seen, accessed, and used by residents, staff and visitors. The MBA indicated the wiring was missing in one of eight home areas, as well as a deficiency list of certain areas in the home yet to be corrected. The MBA indicated all other department staff were not provided any handheld or wearable devices due to cost, but they were to locate a resident or staff that had a wearable device to call for assistance. All visitors and staff, other than direct care nursing staff, did not have access to a RSCRS that could be easily seen, accessed, and used at all times as required.

On one of the resident home areas, two PSWs were providing care to two different residents but could not clear either of their handheld devices. One of the PSW's reported internet issues were identified for a specific resident bedroom and another PSW indicated there was no internet at another resident's bedroom whereby PSW staff could not clear their calls at the point of activation or anywhere near these residents until they could get internet access. The MBA and an IT staff indicated since the issue was not with the staff handheld devices or wearable devices, that it was possibly related to the beacons that signals the RSCRS system. These beacons were in each residents' bedroom and resident areas in the home. The MBA then noted missing transformers in these residents' rooms and that these transformers were not plugged in to an electrical socket as required. The MBA indicated these

transformers were required to be plugged in near each beacon as they were essential to the proper functioning of the RSCRS system. The MBA was not sure this was the cause of the poor internet access in resident room areas but did rectify the clearing of calls for these residents RSCRS.

A PSW indicated they were charging wearable RSCRS devices at the nursing station for three residents. These residents were not provided any replacement wearable RSCRS device as they could not use any other device for the residents, as they were all programmed for each resident specifically. These residents did not have a RSCRS that could be easily seen, accessed, or used at this time. The MBA indicated resident's wearable RSCRS devices were supposed to be charged during a meal time when constant supervision from staff and access to other RSCRS devices to call for emergency were available as required. The Licensee's process and expectancies for nursing were developed, however MBA realized they did not specify the time or schedule for these wearable devices to be charged. Handheld devices were supposed to be charged on the night shift with lower number of nursing staff in the building. Another PSW reported to an inspector that their handheld device was fully charged at the beginning of their shift and had minimal charge three and half hours later and required charging.

A PSW indicated that four residents in another home area, would not wear any wearable devices or any replacement or alternative system. The MBA indicated the next day, that they were aware of the complexity of having these residents accept to wear the RSCRS devices. This was why they were returning to a wired RSCRS that would be available in each resident common area, resident bedroom, bathroom, and tub room as they had prior to the installation of their new RSCRS.

The MBA indicated that the RSCRS education included an in-service session and a review of their RSCRS policy and procedure. Both parts of this education were

required to be fully educated on their RSCRS. The MBA reported this education was still in progress and several staff in the home had not received this education as required.

As such, the home was not equipped with an RSCRS that could be easily seen, accessed, and used by residents, staff, and visitors. The system was also not functioning properly, which posed a significant risk to residents' health and safety as the ability for all users to make a call for assistance when needed, could not be assured.

Sources: Interviews with four PSW's, MBA, an IT staff, observations of resident bedrooms, bathrooms and common accessible areas, observations of eight residents and review of educational material, email communication for the RSCRS system, audit material, policy and procedure for the RSCRS system. [000725]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 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:
Previous non-compliance identified in inspection #2023-1301-0004 regarding Compliance Order (CO) #001 for s. 20 (a) issued to the licensee on October 19, 2023, with two extension requests granted and a CDD on January 31, 2024.

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: Conditions of licence

NC #005 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.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2023_1301_0004 issued on October 19, 2023, with a compliance due date of January 31, 2024.

The required resident-staff communication and response system (RSCRS) that allows calls to be cancelled only at the point of activation was not fully developed or implemented.

The required education for all staff on these procedures related to calls to be cancelled only at the point of activation was not provided.

The required auditing process and corrective actions for this section was not developed or fully implemented.

Rationale and Summary:
An inspector conducted RSCRS observations on three specified home areas during this inspection. The Inspector observed nursing staff with difficulty clearing resident calls on their handheld devices. Their handheld devices and information provided by nursing staff, was that they were supposed to have a two-meter radius to clear resident calls on their RSCRS. The inspector noted challenges by nursing staff in resident areas using their handheld devices to clear calls in these locations due to technical difficulties.

The Manager of building Architecture (MBA) indicated calls could no longer be cancelled unless at the resident's bedside. MBA indicated they had implemented a two-meter radius to the resident or device where the call was coming from. MBA did not understand that a two-meter radius would not be considered at that the point of activation, as the legislation indicates the call can only be cancelled at the point of activation, which the licensee has determined to be the wearable device. This indicated that calls could only be cancelled from the wearable device.

The MBA indicated that education to their RSCRS policy and procedures were not completed or documented for all staff.

The inspector reviewed the audits, which the MBA indicated were not completed or documented as required.

Failure to ensure that the home's RSCRS allowed calls to be cancelled at the point of activation only, posed a potential risk to resident health and safety.

Sources: Observations and interviews with nursing staff on resident home areas of the communication and response system for cancelling calls from the communication and response system at the point of activation purposes, interviews with MBA and record review of their compliance plan related to CO #002. [000725]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003

Related to Written Notification NC #005

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:

Previous non-compliance identified in inspection #2023_1301_0004 regarding Compliance Order (CO) #002 for s. 20 (c) issued to the licensee on October 19, 2023, with two extension requests granted and a compliance due date of January 31, 2024.

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: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their fall prevention and management program when a resident had an unwitnessed fall with injury.
In accordance with O. Reg 246 / 22 s. 11 (1) (b), the licensee is required to ensure that unwitnessed falls require head injury assessments by registered nursing staff, must be complied with.
Specifically, registered nursing staff did not comply with the policy "Falls Prevention and Management policy" #11.00.00 last revised August 2023, which was included in the licensee's Falls Prevention Program.

Rationale and Summary:

A resident sustained an injury following an unwitnessed fall. Registered nursing staff did not comply with the policy and procedure for this resident for their unwitnessed fall.

Specifically the home's Falls Prevention and Management policy indicated that residents who had sustained a witnessed injury or had an unwitnessed fall, that registered nursing staff initiated specific assessments by completing them in Point Click Care (PCC).

The Inspector reviewed these specified assessment paper records on the resident's home area completed for this resident as well as electronic records in PCC and no specified assessment documentation was located for the resident's fall.

An RPN confirmed these specified assessments would have been completed on paper at the time of this unwitnessed fall, as they have just recently implemented this in PCC. This RPN indicated they could not locate any documentation regarding these assessments for this resident from the time of the fall to an hour and a quarter later when the resident went to the hospital.

Failing to complete this resident's required assessments, posed potential risk in deterioration in the resident, going unnoticed after the resident injured themselves during a fall.

Sources: Review of this resident's health records, the home's Falls Prevention and Management policy #11.00.00 last revised August 2023, and interview with an RPN. [000725]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that this resident received a specified assessment by a member of the registered nursing staff on a specified date, using a clinically appropriate assessment instrument that is specifically designed for these assessments.

Rationale and Summary:
The licensee submitted a critical incident report regarding a resident that fell and required external medical attention with significant change in their health status. This resident was considered a high risk for falls and sustained an injury that required a specific medical intervention.

No specified assessment was completed regarding this alteration of skin integrity as required. No documentation was identified in the progress notes of the status of the resident's injury upon return from the external medical treatment location.

A Registered Practical Nurse (RPN) indicated the plan of care was not updated with

their injury or interventions in the resident's care plan or the resident's Electronic Treatment Assessment Record (ETAR) as required.

The Coordinator of Nursing Programs (CNP) indicated this resident should have been assessed upon their return to the home, after their medical intervention. This assessment should have been added to the resident's ETAR for nursing follow up and added to the resident's plan of care.

Failing to assess this resident's injury and update the resident's plan of care posed potential risk for resident deterioration and infection.

Sources: Record review of the resident's health records and interviews with an RPN and the CNP. [000725]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control. Specifically, the licensee failed to ensure staff removed the appropriate Personal Protective Equipment (PPE) in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022". Several staff members did not remove required PPE as per additional requirement 9.1 (e) and (f) related to additional precautions under the IPAC standard.

Rationale and Summary:
A-
Inspector observed for an extended period, staff members exiting several resident's rooms. These staff members were observed exiting these resident rooms and removed their gloves and gowns, then performed hand hygiene. These staff members did not change their mask or clean their eye protection.

Two Personal Support Workers (PSWs) and a Registered Nurse (RN) stated that the education they received was that they did not have to change their masks or clean their eye protection as part of the removal of personal protective equipment process for resident rooms on this type of enhanced precautions.

In an interview with the IPAC Manager, they stated the IPAC Hub had provided direction and education to the home that staff were only required to change their masks every four hours or when visibly soiled when exiting a room on this type of enhanced precautions in an outbreak area.

Approximately three hours later, a staff member with the IPAC Hub confirmed with the inspector that best practice for removal of PPE for these enhanced precautions was to change masks and clean or dispose of eye protection. The staff member with the IPAC Hub stated that there may have been a miscommunication with the education they provided to the home.

As such, not following the appropriate removal of PPE for residents on this type of enhanced precautions, increased the risk of disease transmission amongst residents and staff.

Sources: Observations on a specified date, interviews with two PSWs, an RN, the

Manager of IPAC and staff member at IPAC Hub. [000723]

Rationale and Summary:
B-
On another specified date, an inspector observed no sanitizing wipe containers in the PPE caddy's for four resident rooms on a specified type of enhanced precautions.

A PSW was observed to enter an enhanced precautions resident room for snack service delivery without wearing gloves as required. This PSW was observed to leave this resident room and did not change their mask or visor as required. The PSW indicated to an inspector they did not think they had to wear full Personal Protective Equipment (PPE) when providing a glass of fluids to these residents. They further indicated they had forgot to change their mask or sanitize their visor. This PSW then went into another resident room which had a specified type of enhanced precautions and was not able to sanitize or change their visor as required as there was no sanitizing wipe container available in their PPE caddy. This PSW then went to the previous resident bedroom where there was a sanitizing wipes container at the doorway, but it was empty.

On this same date, a Laboratory Technician was observed exiting a resident room on specified type of enhanced precautions and they did not change their visor or sanitize it. The Laboratory Technician indicated they were aware they were supposed to change their visor or sanitize their visor upon exiting this resident bedroom however there was no PPE available in the PPE caddy for this room to do this task.

Failing to have appropriate PPE in each isolation caddy posed significant risk of transmission of bacteria to other staff and residents in the home area affected.

Sources: Observations on a specified resident home area and interviews with a PSW and a Laboratory Technician. [000725]

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard issued by the Director with respect to infection prevention and control measures for additional precautions.

Rationale and Summary:
C-
On another specified date, an inspector went to the entrance of another resident home area and noted signage present on the front door indicating the home area was in a specified type of outbreak and staff and visitors were asked to wear an N95 masks and eye protection while in the home area.

A PSW was inside a resident's room to respond to the communication and response call from this shared bathroom. This resident was on a specified enhanced precautions and this PSW did not clean their handheld device upon exit of this bedroom, which was used while inside this room as well as placed on the resident's bedside table.

This PSW indicated they should have cleaned their handheld device upon exit of this room that was currently on a specified type of enhanced precautions using Accell wipes. The PSW indicated they were aware they should have wiped down their handheld device after it was used inside this room on droplet precautions.

The next day, the Infection Prevention and Control (IPAC) lead in the home indicated education provided to nursing staff was to clean all items going inside and outside resident on precaution rooms, to use Accell wipes to clean these items every time

they enter and exit rooms in isolation.

Failing to sanitize handheld devices when exiting droplet precaution rooms posed significant risk to extending this infection to other residents and staff in the home.

Sources: Observations on Bankwood unit, Interviews with a PSW and IPAC lead. [000725]

WRITTEN NOTIFICATION: Evaluation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Rationale and Summary:
The licensee's policy to promote zero tolerance of abuse and neglect of residents indicated that the last revision date was November 2022. Interview with the Director of Care (DOC) confirmed that the policy was last revised / evaluated in November 2022, and there was no review done in 2023.

As such, there was potential risk to resident safety by the policy to promote zero tolerance of abuse and neglect of residents not being reviewed and evaluated once in every calendar year.

Sources: policy titled Resident Abuse and Neglect Prevention (RC 4.00.00) last reviewed November 2022, and interview with DOC. [000723]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (1) 1.
Requirements relating to restraining by a physical device
s. 119 (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee has failed to ensure that the requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act, that staff apply the physical device in accordance with any manufacturer's instructions.

Rationale and Summary:
On a specified date at a certain time, a resident was seated in their wheelchair with a seat belt tied behind them. The seat belt clasp was observed at the back of the wheelchair with the belt spacing around their abdomen.

The resident's current care plan, indicated the resident had a custom-made seatbelt restraint and staff were to apply this lap belt every shift. This care plan further indicated to ensure the restraint seat belt was in place when the resident was in their wheelchair.

A progress note on a specified date, from the home's electronic documentation system Point Click Care, indicated an Occupational Therapist (OT) and a vendor showed the nursing staff how to apply/remove the custom made seatbelt restraint.

In the resident's physical chart, instructions from the OT on specified date, stated a rear closure belt in place. The instructions provided specific directions for how to secure and adjust the seat belt around the resident.

The manufacturer's instructions for this lap belt restraint were provided from the Coordinator of Nursing Programs which indicated this was a specific type of seat belt. The instructions indicated the intended use for this lap belt was for positioning a person in a wheelchair and not intended for use as a personal restraint device, where its failure could result in injury. A warning further indicated this pelvic support belt must be worn tightly fitted across the pelvis or thighs at all times.

A Pictogram in these instructions specified that the way the resident had their lap belt applied during observation would have been done incorrectly as this belt was around their abdomen and fastened to the right rear post of the wheelchair versus to the rigid seat base or wheelchair frame below the resident's right hip as indicated in these instructions. These instructions indicated this belt's mounting points should be in these locations to ensure the belt sits around the resident's pelvic area or thighs.

Failing to properly fasten this lap belt restraint to the correct location on the

wheelchair frame, posed risk to the resident for injury. These instructions further indicated this belt is not intended to be used as a personal restraint device.

Sources: Observation of a resident seated in their wheelchair with restraint, record review of the resident's health care records and review of the manufacturer's instructions for this lap belt restraint. [000725]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that the requirements are met regarding all assessment, reassessment and monitoring, including the resident's response, where a resident is being restrained by a physical device were documented.

Rationale and Summary:
A resident was observed to have a lap belt restraint when seated in their wheelchair. This restraint was identified in their plan of care as an intervention for falls prevention after the resident's last fall with injury. The resident was at a high risk of falls with history of several falls in the home.

An Inspector conducted a review of the registered nursing staff monitoring of this lap belt restraint during a specified time for this review. The home uses Electronic Health Records in Point Click Care for their Point of Care (POC) tasks for registered nursing staff to document their reassessment of the resident's need for this lap belt restraint. It was noted that missing documentation entries on several dates. The POC documentation for PSW for the resident indicated this lap belt restraint was applied to the resident on specified dates, during specified shifts.

The RPN indicated registered nursing staff were required to document during a specified time interval for the resident when they were using the lap belt restraint during their shift.

The Coordinator of Nursing Programs (CNP) indicated upon review of the POC documentation for registered nursing staff, that the resident only had the lap belt restraint on a specified shift during certain dates. CNP then reviewed the PSW documentation for this same time period, which indicated this lap belt restraint was applied to the resident during certain shifts on specified dates. CNP indicated registered nursing staff should have documented their reassessment of the restraint needs as required in POC for each shift the restraint was used on the resident. Registered nursing staff were required to document they had reassessed and monitored the resident to require this restraint and that it continued to be required.

As such, missed documentation prevented certainty that the resident's restraint was reassessed.

Sources: Interviews with an RPN and CNP and record review of a resident's health care records. [000725]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (7) 7.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning.

The licensee has failed to ensure that every release of the lap belt restraint device and all repositioning for a resident was documented.

Rationale and Summary:
A resident had a lap belt restraint applied to them while seated in a wheelchair.

Upon review of the home's documentation in the tasks in their Point of Care (POC) electronic documentation system for specified dates, it was noted this documentation was not completed as required. Documentation on these specified shifts were completed for a specified frequency when their POC indicated this device was applied for a different specified frequency within that time frame. POC had the restraint interventions identified as restraint as applied, repositioned / ambulated, safety check, removed, resident not available, resident refused, not applicable. A PSW reported the resident wore the lap belt restraint all day when they were in their wheelchair to help prevent falls. The resident usually went to bed for a rest after a specified meal.

This device intervention had missing documentation entries on several dates for this three-day review.

The Coordinator for Nursing Programs indicated the PSWs were expected to document in POC for a specified time frequency that the resident was wearing a restraint, when it was released, when they were repositioned or ambulated and that the lap belt was verified.

Failing to properly document the application, release of a restraint and all repositioning required, may have potentially prevented appropriate assessment and reassessment of the need for this restraint for a resident's safety.

Sources: Interviews with a PSW, CNP and record review of a resident's health care records. [000725]

WRITTEN NOTIFICATION: Medication management system

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with their written policy and procedure for the medication management system with a resident's narcotic medication.
In accordance with O.Reg 246 / 22 s. 123 (3), the licensee is required to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction

and disposal of all drugs used in the home, must be complied with.
Specifically, registered nursing staff did not comply with the MediSystem services homes policy for "Discontinued Narcotic and Controlled Substances", last revised in December 2023, whereby a resident was administered a discontinued narcotic medication.

Rationale and Summary:
On a specified date, an RPN indicated a resident's narcotic medication had been discontinued since a specified date, however it was not removed from the medication narcotic cart, documented as discontinued and disposed for later destruction as required.

The resident's narcotic and controlled drug administration record indicated the resident received a specified medication as needed (PRN) on specified date at a specified time. This medication was then administered to the resident on a specified date, without any physician's prescription on file.

The Director of Care (DOC) provided their Policy and Procedures Manual for MediSystem services homes last revised in December 2023, for "Discontinued Narcotic and Controlled Substances". Registered nursing staff were required to remove this control sheet and the medications, to then secure with an elastic and place them in the narcotic destruction bin as required.

Failing to follow the policy and procedures regarding the removal of discontinued narcotic medication from the home's active narcotic locked drawer and the documentation of administration of this discontinued medication, posed a potential risk to the resident who was administered a narcotic medication without any physician's prescription.

Sources: Observations of a specific home area's narcotic storage and disposal areas,

record review of the narcotic control sheet for the specified medication and narcotic count sheets from a specified time period, for the specified medication, the policy and procedure from MediSystem policy and procedure manual, the resident's health care records and interview with an RPN and the DOC.[000725]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs that were stored on the front desk at a specified home area nursing station, were kept secure and locked.

Rationale and Summary:
On a specified date, an Inspector observed a plastic basket that had several bottles and tubes of prescribed ointments and creams for residents on the desk in the nursing station of a specified home area. This basket was observed outside the locked medication storage room for this unit. There were no staff in the area and three residents were seated in the dining area next to the nursing station desk.

A PSW indicated that the medication basket was supposed to be locked up, but the RPN was in a meeting so the basket was left on the desk near the medication storage room.

An RPN indicated that prescribed creams and ointments were supposed to be kept locked up in the nursing medication storage room. In the morning, each PSW team

would be responsible to take a basket for resident's care provision. The RPN indicated that it is not best practice, but these baskets are kept on the PSW linen carts which were not kept locked up and kept in the residents' hallways during care.

Failing to ensure that prescribed creams and ointments for residents are kept secure and locked, posed potential risk for resident access and potential harm.

Sources: Observation on a specified home area and interview with a PSW and an RPN. [000725]

WRITTEN NOTIFICATION: Screening measures and declarations for directors and management

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 256 (1)
Screening measures and declarations for directors and management
s. 256 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted before permitting any person to be a member of the licensee's board of directors, its board of management or committee of management or other governing structure.

The licensee has failed to ensure that screening measures were conducted before permitting any person to be a member of the licensee's board of directors, its board of management or committee of management or other governing structure. Specifically, the licensee failed to ensure police record checks for two new board members were received prior to being permitted to be a member.

Rationale and Summary:
An email from a staff member to the Inspector from a specified date, identified that two new members of the board of directors who became members on a specified

date, had not yet provided their police record checks.

In an interview, the staff member stated that they had received a police record check from one board member on a specified date, which was not conducted within six months before they became a member. The staff member stated that this board member had submitted a request for a new police record check. The staff member confirmed they had not received the police record check for the other board member, but they had acknowledged receipt of the request. The staff member stated that both had been offered to become board members and had attended a board of directors meeting without having provided a police record check.

As such, failing to ensure that screening measures, specifically a police record check, was conducted before permitting two board members to be members of the licensee's board of directors, posed a potential risk to resident safety.

Sources: List of board of directors, emails from a staff member, and interview with a staff member. [000723]

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #016 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:

1. Provide training to a specified RN on the licensee's policy regarding zero tolerance of abuse and neglect of residents. Specifically, the licensee shall ensure that the specified staff member is provided training on the expectations specific to their role in the home when responding to an allegation of staff to resident abuse.

2. Written records of the training provided including the date it was provided and the signature of the staff member who received the training, shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents was complied with by a specified Registered Nurse (RN).

Rationale and Summary:

On a specified date at a specified time, a resident reported to an RN that a Personal Support Worker (PSW) had hit them while in a specified home area. The police were notified by the Director of Care (DOC) a couple days after the incident.

The nursing staff schedule for the specified home area during this time period, showed that the PSW worked after the incident occurred and then was placed on leave.
In an interview, a PSW, who was working on the same shift as this PSW, confirmed that the PSW stopped providing care to the resident after they reported the

allegations. However, they stated that the PSW continued to provide care to other residents on the specified home area for the remainder of that day, and the following day.

As per the licensee's policy titled Resident Abuse and Neglect Prevention (RC 4.00.00) last reviewed November 2022, the checklist provided in Appendix A outlined that the staff member who is alleged to have been abusive will be removed from the care area. Additionally, the policy indicated that the police must be notified immediately for all incidents of alleged abuse or neglect involving staff.

The RN confirmed that the PSW was not removed from the care area after the resident reported the allegations and remained on the specified home area providing care to other residents on that specified date. The RN stated that they should have removed the PSW from providing care as per the licensee's policy. The RN also confirmed that they should have immediately notified the police as per the licensee's policy.

The DOC stated that the expectations of registered staff when responding to incidents of alleged staff to resident abuse is that the staff member be removed from providing care and that the police should be notified immediately as per the licensee's policy. The DOC acknowledged that the PSW continued to work until they were placed on leave, and that the police were not notified immediately.

As such, failing to ensure that the licensee's policy to promote zero tolerance of abuse and neglect of residents was complied with by an RN placed residents at risk of abuse.

Sources: a resident's progress notes, nursing staff schedule for a specified time period, internal investigation notes, policy titled Resident Abuse and Neglect Prevention (RC 4.00.00) last reviewed November 2022, CIR, interviews with a PSW, an RN and DOC. [000723]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #002 Doors in a home

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

The licensee shall:

1. Ensure that the doors leading to the dish rooms in two home area serveries are closed and locked when unsupervised.
2. Conduct daily audits for four weeks, including on weekends and alternating between day and evening shifts, to ensure that these doors leading to non-residential areas are kept closed and locked when not being supervised by staff. These audits will include the date, time, name, and signature of the staff member conducting the audits.
3. Take immediate corrective action if the doors are found to be unlocked and not directly supervised by staff. Maintain a documented record of the corrective actions taken.

4. Written records are to be maintained for #2 and #3 until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not supervised by staff.

Rationale and Summary:

On a specified date, at a specified time, the Inspector observed doors in the a specified home area servery to be unlocked and open. A half door leading to the servery was propped open by a dirty dish cart leading to a second door to the servery dish room which was observed to be unlocked and left open. The dish room contained hot water, coffee, and juice machines, an industrial dishwasher and cleaning chemicals. A third door leading from the dish room to a hallway with access to a service elevator was observed to be left open.

For a specified time period, six residents were present in the dining room with the above mentioned doors left unlocked and open. No staff members were present during this time period.

Around 21 minutes later, a PSW entered the servery area and placed a cup in the dirty dish cart that was propping open the half door to the servery. The PSW did not close any of the doors and left the area.

Around 9 minutes later the same PSW returned to the servery and started assembling the snack cart.

The PSW stated that the door to the dish room should have been closed and locked when there were no staff members present to supervise as it was considered a non-residential area.

Later, at a specified time, the Inspector observed the door to the dish room in a different home area servery was unlocked and left open. There were no staff members present in the area at the time of observation. The RPN stated that this door should have been closed and locked.

In a return observation on the same home area the following day, the Inspector observed the door to the dish room to be unlocked, left open and was unsupervised for a specified time period. A different PSW stated that the door may have been left open by a staff member after they completed the afternoon snack pass and acknowledged that it should be locked and closed when staff are not present.

The Nutrition Supervisor stated the expectation is that the dish room doors in the serveries be closed and locked when staff are not present to supervise. The Nutrition Supervisor acknowledged that the dish room doors should have been closed and locked during the above observations.

As such, these doors to non-residential areas were not closed or locked which increased the potential risk of injury to residents on two specified home areas.

Sources: Observations from specified dates, and interviews with two PSWs, an RPN, and the Nutrition Supervisor. [000723]

This order must be complied with by May 30, 2024

COMPLIANCE ORDER CO #003 Communication and response system

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 20 (g)
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,

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

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

The licensee shall:

1. Ensure that their Resident to Staff Communication and Response System (RSCRS) that uses sound to alert staff, is properly calibrated so that the level of sound is audible;
2. Document education to all staff that carry handheld devices, on the importance of keeping the volume turned on and that the sound is audible at all times until such time this volume feature on the handheld devices is no longer adjustable;
3. Audits shall be completed twice a week, alternating resident home areas and shifts to ensure their handheld device volume controls are audible. These audits will include signature, date, time, staff names and home area for each audit to support that a member of the management team or delegate has conducted these audits. The audits will be performed until such time the Ministry of Long-Term Care has deemed that the licensee has complied with this order; and
4. Include documented corrective actions required for each issue identified and any outcomes.

Grounds

The licensee has failed to ensure that their Resident to Staff Communication and Response System (RSCRS) that uses sound to alert staff, was properly calibrated so that the level of sound was audible to two PSWs as required.

Rationale and Summary:

On a specified date, the Inspector attempted to use the call bell cord in the common lounge on a specified home area. The Inspector pulled the cord in the call bell station and an audible alarm sounded down the hallway. A PSW was next to the lounge and the Inspector asked to confirm they received a call from the lounge. The PSW reported they did not. The Inspector then returned the call bell panel to its original position. The Inspector then went to the dining room and pulled the cord for the call bell station and an audible alarm in the distance was heard.

The same PSW indicated they had received the call on their handheld device now, however the Inspector indicated the calls were not audible. The PSW indicated no, they did not hear anything, but increased the volume on their handheld device as the volume was off as reason for no audible alarm.

On a different date, the Inspector went to dining room in a different home area at a specified time and observed a red button on the wall near the door that said urgent. The Inspector pushed it and waited. A few minutes later, a PSW was walking past the dining room in the hallway and the Inspector asked if they received a call for the dining room. The PSW took out their handheld device and their wearable device. The handheld device did not show any call and then the PSW pushed their wearable device and then the calls appeared and an audible ring to the handheld device. The PSW did not have any audible sound from the handheld device until they pressed their wearable device to then receive calls.

MBA indicated the audible ring tone for the handheld devices had volume control as staff could turn the audible level off at this time.

Failing to have an audible notification for their Resident to Staff Communication and Response System (RSCRS) posed significant risk to residents in delay or not receiving assistance, as this was not communicated to staff as required.

Sources: Observations of the audible sound for handheld devices on two specified home areas, interviews with two PSWs and MBA. [000725]

This order must be complied with by May 30, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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

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.