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

Original Public Report

Report Issue Date: June 25, 2024

Inspection Number: 2024-1200-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Lindsay Nursing Home, Lindsay

Lead Inspector	**Inspector Digital Signature**
Laura Crocker (741753)	Laura L Crocker Digitally signed by Laura L Crocker Date: 2024.07.10 11:59:56 -04'00'

Additional Inspector(s)
Sami Jarour (570)
Jennifer Batten (672)
Sharon Connell (741721)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14- 17, May 21-24, May 27-29, 2024.

The following intake(s) were inspected:
- two intakes regarding an allegation of resident-to- resident abuse.
- two intakes regarding an allegation of Improper/incompetent care of a resident.
- an intake regarding missing medication
- four intakes regarding falls that resulted in an injury.

- An intake regarding Infection Prevention and Control and late reporting.
- An Intake regarding missing medication.
- An Intake regarding an allegation of staff to resident abuse.
- three intakes regarding a controlled substance unaccounted for.

Previously Issued Compliance Order(s)

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

Order #008 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 123 (2) inspected by Laura Crocker (741753)

Order #010 from Inspection #2023-1200-0003 related to FLTCA, 2021, s. 6 (1) (c) inspected by Laura Crocker (741753)

Order #003 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 40 inspected by Sami Jarour (570)

Order #002 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 20 (a) inspected by Sharon Connell (741721)

Order #007 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 102 (8) inspected by Jennifer Batten (672)

Order #009 from Inspection #2023-1200-0003 related to FLTCA, 2021, s. 3 (1) 18. inspected by Sharon Connell (741721)

Order #011 from Inspection #2023-1200-0003 related to FLTCA, 2021, s. 19 (2) (c) inspected by Jennifer Batten (672)

Order #004 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Laura Crocker (741753)

Order #005 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 77 (8) inspected by Jennifer Batten (672)

Order #012 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 79 (1) 10. inspected by Jennifer Batten (672)

Order #006 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Jennifer Batten (672)

Order #001 from Inspection #2023-1200-0003 related to FLTCA, 2021, s. 6 (4) (a) inspected by Sharon Connell (741721)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #013 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 140 (2) inspected by Laura Crocker (741753)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home

Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that resident #005 was treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, worth and individuality.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director alleging staff to resident physical abuse.

Resident #005 reported they were forcefully transferred into their chair by two personal support workers (PSW) staff against their wishes.

As a result of their investigation, the licensee concluded that staff did use physical force causing injury and violated the resident's right to choose.

In separate interviews, resident #005 indicated they were upset and devastated as they had never ever been treated that way. PSW #101 acknowledged that the resident was transferred from bed against their wishes. The Director of Care (DOC) acknowledged when the PSWs #101 and #102 got the resident out of bed against their will, they went against the resident's right to be treated with dignity and respect.

Failing to respect and promote resident #005's right to be treated with respect and dignity during the provision of care placed the resident at risk of emotional and physical harm.

Sources: A CIR, clinical records for resident #005, and interviews with resident #005, PSW #101 and the DOC. [570]

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to ensure that every resident has the right to have their lifestyle

and choices respected and promoted.

Rationale and Summary:
A CIR was submitted to the Director alleging staff to resident abuse.

Resident #005 reported they were forcefully transferred into their chair by two PSW staff against their wishes.

As a result of their investigation, the licensee concluded that staff did transfer the resident to their chair against their wishes.

In separate interviews, resident #005 indicated they were upset and devastated as they had never ever been treated that way. PSW #101 acknowledged that the resident was transferred from bed against their wishes causing the resident distress.

Failing to respect and promote resident #005's right to have their lifestyle and choices respected placed the resident at risk of emotional and physical harm.

Sources: A CIR, clinical records for resident #005, and interviews with resident #005, PSW #101 and the DOC. [570]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure a resident's plan of care provided clear directions to

staff and others who provided direct care to the resident related to continence care and their transferring and mobility needs.

Rationale and Summary:
Resident #024's call bell was activated, and they were observed calling for help for a transfer off of the toilet.

The resident's plan of care directed staff to transfer the resident with one staff assist and in a separate section, it directed staff to use two staff for transfers.

PSW #131 and Registered Practical Nurse (RPN) #130 indicated that two staff are to assist the resident with transfers.

The RAI Coordinator indicated the plan of care should have been updated. The DOC indicated it was the expectation in the home for residents' plans of care to provide clear directions to the staff who provide direct care to the residents.

By not ensuring resident #024's plan of care provided clear directions to staff and others who provided direct care to the resident, they were placed at risk of not having their needs met, as required.

Sources: Observations; resident #024's current Kardex and written plan of care; interviews with PSW #131, RPN #130, the RAI Coordinator and the DOC. [672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

1) The licensee failed to ensure that resident #024 received care as was specified in their plan, specific to continence and toileting.

Rationale and Summary:
Resident #024's call bell was activated, and they were observed calling for help for a transfer from the toilet.

Review of resident #024's current plan of care indicated the resident was at risk for falling therefore was not to be left unattended on the toilet.

During separate interviews, the resident, PSW #131 and RPN #130 indicated it was part of the resident's routine to be assisted onto the toilet, instructed to ring the call bell for further assistance when needed and left unattended.

By not ensuring resident #024 received care as was specified in their plan specific to not being left unattended on the toilet, the resident was placed at risk of sustaining injuries and/or falling.

Sources: Observation; resident #024's current Kardex and written plan of care; interviews with PSW #131, RPN #130 and the DOC. [672]

2) The licensee has failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan.

Rationale and Summary:
A CIR was submitted to the Director for an allegation of improper/incompetent treatment.

Resident #026 reported that PSWs #101 and #112 assisted them from bed into wheelchair without using the mechanical lift.

The resident's plan of care directed the resident required the use of a mechanical lift with two staff assistance for all transfers.

The DOC and PSW #101 acknowledged resident #026 as was improperly transferred.

Failure to ensure that resident #026 was transferred as specified in the plan of care placed the resident at potential risk of harm due to improper transfer.

Sources: A CIR, clinical records for resident #026, and interviews with PSW #101 and the DOC. [570]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that resident #004 was protected from an incident of neglect by staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary:
Resident #004's incontinent product was not changed for approximately 12 hours.

An internal investigation was completed that identified approximately five PSWs failed to provide continence care to the resident.

PSW #119 and the DOC verified resident #004 did not receive personal care during the approximate 12-hour period.

By not ensuring resident #004 was protected from an incident of neglect by staff, the resident was placed at risk of skin breakdown, physical discomfort, and emotional distress.

Sources: CIR; internal investigation and risk management notes and staff discipline letters; resident #004's clinical records, interviews with the Behavioural Supports Ontario (BSO) Lead, RPN #113, PSW #119 and the DOC. [672]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #006 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.

1) The licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of a residents and co-resident, was complied with.

Rationale and Summary:
A CIR was submitted to the Director, indicating there was a unprovoked physical altercation between residents #043 and #044.

The Home's Zero Tolerance for abuse and neglect policy indicated when there was a resident-to-resident incident of physical abuse staff must immediately inform the Nurse and Executive Director /designate. The department head/designate will begin the investigation as soon as possible and the POA will be notified. The policy indicates the POA will be notified, and all persons involved in incident are identified, written statements received, and interviews conducted- within 24 hours where possible. Identify visitors who may have been present at the time of the incident have been interviewed. All documentation is to be placed in an investigation file.

The Administrator acknowledged part of the home's Zero Tolerance of abuse and neglect policy included keeping all the documentation in an investigation file, with interview notes and statements. The Administrator provided the inspector the home's investigation for this CIR, in a plastic folder. The folder provided did not include the abuse and neglect investigative checklist, an interview or statement from the Dietary Consultant.

There may have been a increased risk when the Dietary Consultant was not interviewed and the checklist was not completed as interventions for the resident with responsive behaviours may have been missed to prevent further altercation with co-resident's.

Sources: the licensee's policy, the licensee's investigation notes, interview with the Administrator. [741753]

2) The licensee failed to ensure that records were kept of the investigation into the physical abuse of resident by another resident, as reported in a CIR.

Rationale and Summary:
A CIR and was submitted to the Director describing an incident of resident-to-resident abuse between resident #034 and #033.

The home's policy prevention of abuse policies indicated that investigative documentation was to be placed into a file, including but not limited to: incident report, risk management report, all statements, all interview notes, copies of assessments- initial and follow-up, copy of original care plan, and copy of the updated care plan.

The Executive Director (ED) confirmed in an interview, that there was no investigation package kept.

By failing to keep an investigative record, as per the licensee's prevention of abuse policies, there was no impact to the residents involved in the abuse incident.

Sources: A CIR, residents #033 and #034 clinical records, the licensee's policies, ED email and interview. [741721]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of a resident, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary:
A CIR was submitted to the Director for an allegation of improper/incompetent treatment of resident #026.

Resident #026 indicated they were assisted in a transfer from bed into wheelchair by two PSWs without using the mechanical lift.

The DOC acknowledged resident #026 as was improperly transferred and was placed at risk. The DOC acknowledged that the incident was not immediately reported to the Director.

Failure to immediately report allegations of improper care to the Director could lead to further incidents without proper follow-up.

Sources: A CIR, clinical records for resident #026, and interview with the DOC. [570]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an allegation of abuse between resident #033 and #034 was immediately reported to the Director.

Rationale and Summary:
A CIR was reported to the Director alleging resident to resident abuse. The incident was reported the day after the incident occurred.

The ED confirmed that it was mandatory to report alleged/suspected abuse incidents the same day.

By failing to immediately report an incident of physical abuse by between the residents, that resulted in harm or a risk of harm to the resident, there was no impact to the residents.

Sources: A CIR, clinical records for resident's #033 and #034, interview with ED. [741721]

WRITTEN NOTIFICATION: CONDITIONS OF LICENCE

NC #009 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 conditions of #4 and #5 of Compliance Order

#013 from inspection #2023_1200_0003, related to O. Reg, s. 140 (2), Administration of Drugs, served on Dec 21, 2023, with a compliance due date March 31, 2024.

Specifically, the licensee did not ensure that registered staff were provided re-education when they did not adhere to the medication policy and follow the physician orders to administer medication, as prescribed to residents.

Rationale and Summary:
The licensee was ordered to comply with the following:
4) Conduct daily audits of diabetic residents electronic Medication Administration Record (e-MAR) for three weeks to ensure that registered staff are following physician orders and administering medication, as prescribed.

5) Analyze the audit results to determine which registered staff are not adhering to the medication administration policy and provide re-education, as needed. Ensure a documented record is kept including who completed the audit, the dates the audits were completed, any incomplete documentation identified, and the date and name of staff that required re-education. Provide the audit records to the Inspector immediately upon request.

Review of the DOC's daily audits indicated a column for the DOC to document if a resident's medication was administered as per the Physician orders and to list any incomplete documentation identified. At the end of the three-week auditing period the DOC was to analyze the audit.

Review of the DOC's medication audits indicated that on separate occasions, approximately seven residents had not received their medication as prescribed. The DOC's audit further indicated numerous residents had refused their medication. The

DOC reported for those resident's it was their right and if the medication was refused and it was a one off, the nurse's used their skill knowledge and judgement and did not notify the Physician that the medication was not given as prescribed.

The home's Medication policy, indicates, a medication incident is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Medication incidents may be related to professional practice, drug products, procedures, and systems, and include prescribing, order communication, product labelling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. The CareRX medication incident document list types of medication incidents including late/missing delivery, referring to medications that are not delivered at the time required to permit safe medication administration, dose omission, referring to a dose that was prescribed for a resident was not given or omitted, common examples include finding a leftover dose in a medication cart or discovering that a medication strip pack is missing a pill.

The home's Documentation policy indicates documentation includes incident reports, medication and treatment records, narrative notes, and Physician's orders.

The home's orientation for registered staff indicates if a resident is refusing their medication the registered staff are to inform the nursing supervisor. In an email sent by the DOC they indicated if a resident is refusing their medication, it auto populates a progress note. The Nursing managers review the 24-hour report and can determine if a resident has been refusing their medication. If a resident is refusing medication on multiple occasions, then a progress note is expected. For a one-time occurrence they use their nursing skills and judgement. The DOC acknowledged that resident's refusal of medication is a gap and staff required more education.

The DOC audits and analysis indicated the DOC did not ensure that the registered staff were following the physician orders and administering medication, as prescribed for the above residents. The DOC analysis did not determine which staff were not adhering to the medication policy, including filling out medication incident reports, as required when medication was not available and using the backup Pharmacy. The DOC's audits did not indicate which registered staff did not follow up and collaborate with the Pharmacy and/ or physician to ensure the resident's medication was administered as prescribed, when it was refused by the resident, when the medication was on back order, when the resident's medication was not covered, when the resident's medication was not given as they were sleeping and when the resident's blood sugar was less than six that staff followed the home's hypoglycemia protocol. The DOC's audits did not indicate that staff had received re-education as per the order when the above residents did not receive their medication as prescribed and did not indicate any incomplete documentation.

The resident's health may have been at an increased risk when the registered staff did not give the resident's their medication as prescribed and comply with the Compliance Order #013.

Sources: The licensee's medication policies, the licensee's policy for documentation, email correspondence, the resident's clinical records, and electronic medication records (e-Mar), audits for compliance order. [741753]

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 #009

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:
Intake: #00104781, Follow up #1- CO# 013/2023-1200-0003, O. Reg 140 (2), Administration of Drugs, CDD March 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: POLICIES, ETC., TO BE FOLLOWED, AND RECORDS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee failed to ensure the internal policy related to narcotics and controlled substances was complied with.

According to the O. Reg. 246/22, r. 148 (1) (c), every licensee shall ensure as part of the medication management system, that a written policy was developed in the home that provided for the ongoing identification, destruction and disposal of all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act.

O. Reg. 246/22, r. 123 (1), indicates every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimize effective drug therapy outcomes for residents. O. Reg. 246/22, r. 123 (2) states the licensee shall ensure that written policies and protocols are developed for the system and r. 123 (3) (a) states the written policies and protocols must be implemented.

Rationale and Summary:
A CIR was submitted to the Director alleging a controlled substances for resident #041 had gone missing.

Internal investigation notes indicated staff had not been completing the controlled substance count as per the licensee's policy.

During separate interviews, RPN #113 verified the medication was discovered missing. The DOC verified the expectation in the home was for Registered staff to follow internal policies related to medication management and administration. The DOC verified RPN #127 had not followed the internal policies.

By not ensuring the internal policies related to narcotic counts and medication management were followed, resident safety was placed at risk.

Sources: A CIR; internal policy; investigation notes, medication incident report, risk management report; interviews with RPN #113 and the DOC. [672]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the home's falls prevention and management program was evaluated and updated annually.

Rationale and Summary:
During an inspection of a CIR related to a fall incident, the licensee's falls prevention and management program was reviewed. The review indicated the program was evaluated in 2023, with no comparison data related to the program goals and indicators from the previous year.

The Administrator indicated that the home's falls prevention and management program was not evaluated in 2022 as no documentation could be found that an evaluation was completed in 2022.

Failure to complete the annual evaluation of the home's falls prevention and management program may have resulted in missed opportunities to improve the program.

Sources: Falls prevention and management program, evaluation 2023, interview with the Administrator. [570]

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #012 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.

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary:
Inspector #672 observed PSW #139 transporting resident #028 using improper equipment.

During separate interviews, PSW #139 indicated the home did have transport wheelchairs available for staff to utilize if a resident was physically incapable of walking down a hallway, but they had not utilized one for resident #028. The DOC indicated it was not an accepted practice in the home for staff to transport residents while seated without utilizing a wheelchair.

By not ensuring that PSW used safe transferring and positioning techniques when assisting the resident, the resident was placed at risk of falling or sustaining a physical injury.

Sources: Observations; resident #028's current Kardex and written plan of care; interviews with PSW #139 and the DOC. [672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident, who was at risk of altered skin integrity, received a skin assessment upon the resident's return from hospital.

Rationale and Summary:
Resident #004 was transferred to the hospital for assessment, and returned to the home the following day. They did not receive a skin assessment upon their return from the hospital. The resident was noted to have altered skin integrity when assessed the next day. In addition, the resident had dressings that were not removed upon return from the hospital so that all areas of the resident's skin could be assessed.

RPN #113 indicated they were unaware a skin assessment was required. The DOC verified the resident had not received a skin assessment upon the resident's return from hospital, which was an expected practice.

By not ensuring the resident receive a skin assessment upon their return from hospital, the resident was placed at risk of not having area(s) of altered skin integrity assessed by an authorized person, which could lead to skin breakdown and/or pain or discomfort.

Sources: Resident #004's progress notes, pain assessments and skin assessments, risk management, internal investigation notes and educational information provided to RPN #113, interviews with RPN #113 and the DOC. [672]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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 ulcers, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain,

promote healing, and prevent infection, as required,

The licensee failed to promote healing by initiating immediate interventions post physical abuse, specifically 72-hour skin integrity monitoring of resident #034's impact site, as required. As per O. Reg. 246/22, s. 55. (3) "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

Rationale and Summary:
A CIR was submitted to the Director alleging an incident of resident-to-resident physical abuse.

Resident #034 confirmed that they had been hit by resident #033. Resident #034 sustained a minor injury.

RN #146 acknowledged that even though an injury isn't found on an initial head to toe assessment, bruises often show up after 24 hours so the nurse would be expected to make a progress note about their monitoring of the area for bruises, swelling, and pain, and schedule this monitoring in the TAR usually for five days for morning shift, so that the nurse coming on the next day would know to monitor the area and take pictures if there was any altered skin integrity. Nurses are expected to document their assessments in the progress notes.

The Assistant Director of Care (ADOC) confirmed that registered staff should have created a treatment administration record (TAR) entry to instruct registered staff to monitor resident #034's area of injury for the first 72 hours after the physical abuse incident and this was not done.

No documentation to support an assessment had been completed after the incident for 72 hours.

According to the licensee's prevention of abuse policies, all direct care staff were to be advised at the start of their shift, the need for additional supports/ interventions to be provided to the resident - to continue for a minimum period of 72 hours or longer as required by the resident's needs.

By failing to initiate a post abuse 72-hour skin integrity monitoring intervention for resident #034's, the licensee placed the resident at potential risk of complications related to delayed treatment of altered skin integrity.

Sources: Resident #034's clinical records, the licensee's prevention of abuse policy, staff interviews with RN #146 and ADOC. [741721]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed.

Rationale and Summary:
The DOC and a PSW reported resident #043 had responsive behaviours. One of the interventions to manage the resident's responsive behaviours during care was to

talk about a city where they lived. The BSO lead reported that if this was an intervention that helped to manage the resident's responsive behaviour during care then the care plan should be updated to include this intervention.

Review of the resident's plan of care did not include talking to the resident about the city they lived in, to support them during personal care.

When the resident's plan of care was not updated to include interventions for the registered staff to follow, the resident was at an increased risk to harm themselves.

Sources: resident #043's clinical records, interview with the PSW #144 and BSO lead and DOC. [741753]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #016 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.

The licensee failed to ensure that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented, when resident #033 demonstrated responsive behaviours.

Rationale and Summary:
A CIR was submitted to the Director regarding an allegation of resident to resident abuse involving resident #034 and #033.

RPN #104 (2023 RAI Coordinator) indicated that the day after the incident they updated the care plan based on the 24-hour report using standardized responsive behaviour interventions as they did not know the resident well. The Behaviour Supports Ontario (BSO) Lead would then be expected to investigate further and make changes to the care plan that were specific to that resident.

The BSO Lead confirmed that the resident was not assessed as per policy in the first 48 hours after the critical incident, as there should have been progress notes to indicate that the dementia observation system (DOS) was reviewed and there was not. They explained that there was no analysis done of the post incident DOS data collected for resident #033, because the calculations would have meant nothing, as the observation tool was only completed for three days, when it should have been done for five days.

The BSO Lead wrote a progress note, 72 hours after the physical abuse incident, indicating that resident #033 was at baseline with no further physical expressions observed during the 72-hour DOS.

There were no progress notes documenting the resident's responses to the standard responsive behaviour interventions that were added to the care plan.

By failing to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented, the licensee placed other residents at risk of harm.

Sources: Resident #033's clinical records, staff interviews (RPN #104 and BSO Lead). [741721]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (b)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The licensee failed to advise direct care staff at the beginning of every shift, of the need for heightened monitoring of resident #033's responsive behaviours, which posed a potential risk to the resident and others.

Rationale and Summary:
A CIR was submitted to the Director for an allegation of abuse between resident #034 and #033.

Resident #033's care plan was updated one day after the allegation and included the newly initiated behaviour interventions.

RN #146 confirmed that when care plans were updated with new interventions after a critical incident, registered staff were expected to provide shift change reports to the personal support worker's (PSW's) at 0700, 1400, 2200, and after providing the education, they would get the staff to sign the attendance sheet that was attached to the updated Kardex.

The DOC and ADOC confirmed that the attendance sheet attached to the updated Kardex, used for documentation of shift-to-shift staff communication about the updated responsive behaviour interventions, was not found in the home for resident #033.

According to the licensee's policy for prevention of abuse, all direct care staff were to be advised at the start of their shift, the need for additional supports/ interventions to be provided to the resident - to continue for a minimum period of 72 hours or longer as required by the resident's needs, including that staff should have a huddle to share interventions.

By failing to advise direct care staff at the beginning of every shift, of the need for heightened monitoring of resident #033's responsive behaviours, the licensee placed the resident and others at potential risk of harm.

Sources: Resident #033's clinical records, the licensee's prevention of abuse policies, staff interviews with RN #146, the ADOC and the DOC. [741721]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 27 (2) OF ACT

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 3. iv.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,

iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and

The licenses has failed to ensure whether a family member, person of importance or a substitute decision-maker of a resident who was involved in an incident and reported to the Director was contacted and the name of such person or persons.

Rationale and Summary:
A CIR was submitted to the Director for an allegation of abuse involving resident #043 and #044.

Resident #043's progress note did not indicate if the residents Substitute Decision Maker (SDM) was called, and what their response was,

The CIR indicated resident #043's SDM would be updated. There was no Amendment to the CIR, indicating the SDM was called and what the family members response was.

The DOC reported they recalled calling the resident's SDM the day the incident happened however agreed the resident's SMD name was not included on the CIR.

When the licensee did not indicate the SDM's name and their response, the home did not maintain transparency.

Sources: CIR, the resident #043 and 044's clinical records, interview with the DOC [741753]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary:
An enteric outbreak was declared in the home, but the Director was not notified for more than 24 hours after the declaration occurred.

By not ensuring the Director was immediately notified, as required, transparency between the licensee and the Director was placed at risk.

Sources: A CIR; interviews with the Infection Prevention and Control (IPAC) Lead and the Infection and the IPAC Specialist. [672]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
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):
3. A missing or unaccounted for controlled substance.

The licensee failed to ensure the Director was notified within one business day of an incident of a missing controlled substance.

Rationale and Summary:
A Critical Incident was submitted to the Director which indicated a controlled substance had gone missing.

During the internal investigation, the Assistant Director of Care (ADOC) indicated that approximately one month earlier, another missing controlled substance had also gone missing. They had not reported this incident to the Director nor conducted an internal investigation into the cause.

The DOC verified that an incident of a missing controlled substance was not reported to the Director within one business day, as required.

By not ensuring the Director was notified as required, transparency between the licensee and the Director was placed at risk.

Sources: A CIR, mediation incident report, internal investigation notes and risk management report; interview with the DOC. [672]

WRITTEN NOTIFICATION: MONITORED DOSAGE SYSTEM

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 134 (2)
Monitored dosage system
s. 134 (2) The monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification

activities.

The licensee failed to ensure the monitored dosage system supported monitoring and drug verification activities.

Rationale and Summary:
RPN #126 had reported they failed to complete an assessment of a resident with RPN #127 at the beginning of their shift to ensure medication patches were still in place. When they assessed the resident later, the patches were missing. An internal investigation was completed, but the patches could not be located.

A review of the internal policies indicated the expectation in the home was for the Registered staff from the oncoming and outgoing shifts to physically assess each resident who received this medication via patch therapy to ensure the patches were in place and administered appropriately, which was documented and signed by each of the Registered staff members.

The DOC indicated the expectation in the home was for internal policies to be followed to ensure drug verification activities were completed, as required.

By not ensuring drug verification activities were completed as required, resident's health was placed at risk of possibly experiencing uncontrolled pain due to not having analgesic patches applied, as ordered.

Sources: A CIR, medication incident report, internal investigation notes, risk management report, the licensee's medication policies, interview with the DOC. [672]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee failed to ensure that every medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary:

A CIR was submitted to the Director which indicated a resident's controlled substance had gone missing. During the internal investigation, the ADOC indicated that approximately one month earlier, another missing controlled substance had gone missing for the same resident. They had not reported this incident nor conducted an internal investigation into the cause.

A review of the internal investigation notes, risk management assessment and resident #015's electronic health care record did not indicate the medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

During an interview, the DOC verified the ADOC had not reported the initial medication incident to any of the required individuals when it occurred, therefore had not been documented in a medication incident report or the resident's electronic health care record.

By not ensuring the medication incident involving a resident's missing controlled substance was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, there was a risk of not having medication incidents assessed to prevent a recurrence.

Sources: A CIR, resident #015's electronic health care record, medication incident reports, internal investigation notes and risk management report; interview with the DOC. [672]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure that every medication incident was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider.

Rationale and Summary:
A CIR was submitted to the Director which indicated a controlled substance for resident had gone missing. During the internal investigation, the ADOC indicated that approximately one month earlier, the same resident had been noted to have another missing controlled substance.

A review of the licensee records and the resident's electronic health care record did not indicate the medication incident was reported to the resident, the resident's substitute decision-maker (SDM), the DOC, the Medical Director, the resident's attending physician nor the prescriber of the drug and the pharmacy service provider.

During an interview, the DOC verified the ADOC had not reported the initial medication incident to any of the required individuals when it occurred.

By not ensuring the appropriate individuals were notified of the medication incident involving resident #015's missing controlled substance, trust between the licensee and shareholders was placed at stake due to the lack of transparency.

Sources: A CIR, medication incident report, internal investigation notes and risk management report, resident #015's records, and an interview with the DOC. [672]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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; or

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1) The Falls Lead and the Physiotherapist will prepare a list of residents who are identified at high risk for falls.

2) The Falls Lead and the RAI Coordinator will review and update the plans of care for all residents identified at high risk for falls to ensure the falls risk is identified in the plans of care. Keep a record of who conducted the review, who updated the plan of care and identify non compliances found.

3) The DOC will review with the multidisciplinary team the plan of care for each resident identified at high risk for falls to ensure the plan of care is current and interventions for falls prevention and management are up to date. Keep a record of who participated in the review, who updated the plan of care and any identified non compliances.

4) The DOC or a designate will provide training to all staff who are involved and/or responsible for updating the plan of care related to falls prevention and management, how and when to update the plan of care, and keep a record of the training.

Grounds
The licensee has failed to ensure that resident #027 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A CIR was submitted to the Director for a fall which required the resident to be transferred to the hospital due to injury.

The resident's fall risk was assessed initially, and they were determined to be at low risk for falls, and universal precautions were implemented. At a later date, the resident's risk for falls changed to high risk.

The resident's plan of care indicated the plan was not updated with the change of resident's fall risk from low to high, and the universal precautions remain unchanged despite the resident's being assessed at high risk for falls. No new interventions were included.

Interviews with RPN #113 and the Residents Care Coordinator (RCC) #105 indicated that the plan of care for resident #027 should have been updated with new interventions when the resident was determined at high risk for falls. The RPN and the RCC acknowledged the care plan was not updated until the resident returned from the hospital.

Failing to update resident #027's plan of care with fall prevention interventions based on the resident's assessed need of high risk for falls, could have contributed to the resident's falls.

Sources: A CIR, clinical records for resident #027, the licensee's falls policies, interviews with RPN #113 and RCC #105. [570]

This order must be complied with by September 6, 2024

COMPLIANCE ORDER CO #002 PERSONAL ITEMS AND PERSONAL AIDS

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

Personal items and personal aids

s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

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

The licensee shall:

The DOC or a nursing designate will audit twice per week for a period of four weeks of shared resident bedroom and bathrooms, to ensure that all personal items are appropriately labelled with the resident's name. Audits are to identify the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make available to Inspectors immediately upon request.

Grounds

The licensee failed to ensure that personal items were labelled, as required.

Observations during the inspection revealed there were multiple personal items in shared resident bathrooms and bedrooms such as used roll-on deodorant, hair combs and brushes, wash basins, bedpans/urinals, finger and toenail clippers,

soaps, toothbrushes, toothpastes, and personal make-up which were not labelled as required with the resident's name. PSW staff were unable to indicate who some of the personal items belonged to. During separate interviews, PSWs, RPNs and the IPAC Lead verified the expectation in the home was for all personal items to be labelled with the resident's name.

By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations; interviews with PSWs, RPNs and the IPAC Lead. [672]

This order must be complied with by August 9, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, to be paid within 30 days from the date of the invoice.

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

Compliance History:
CH is a COHP from inspection #2022_1200_0001 and a CO from inspection #2021_673672_0039.

This is the second 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.

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Follow-up #1 - CO #013 / 2023-1200-0003, O. Reg 246/22 s. 140 (2) , Administration of Drugs, March 31, 2024, RIF $500

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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

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.