Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date October 12, 2022
Inspection Number [2022_1144_0001]
Inspection Type
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Caressant-Care Nursing and Retirement Homes Limited

Long-Term Care Home and City
Caressant Care Woodstock, Woodstock

Lead Inspector
Melanie Northey (563)

Additional Inspector(s)
Ali Nasser (523)

Inspector Digital Signature
Melanie Northey
Digitally signed by Melanie Northey
Date: 2022.10.17 08:58:35 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 8, 9, 10, 11, 12, 15, 17, 18, and 22, 2022

The following intake(s) were inspected:
- Intake #014607-22 related to the Proactive Compliance Inspection

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)
O. Reg. 246/22 [s. 97]

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Observation of the main floor hallway leading to the kitchen, maintenance and storage areas showed open boxes with containers of Bioesque Botanical Disinfectant, Accel concentrate cleaner and disinfectant, Diversey Cleaner and Disinfectant. Residents could access the hallway, but no residents were observed in that hallway at that time.

The Executive Director (ED) stated residents do not usually access this area but acknowledged there was risk. The ED removed all cleaning and disinfecting container boxes from the hallway and made them inaccessible for residents.

Sources: Observation and staff interview.

Date Remedy Implemented: August 8, 2022
[523]

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)
O. Reg. 246/22 [s. 102 (2)(b)]

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

IPAC Standard 10.1 stated, “The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.”

Public Health Ontario Fact Sheet Titled, Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes stated “do not use expired product. Be sure to note product expiration date when selecting product.”

There were three bottles of Plant Voice Alcohol Based Hand Rub (ABHR) with an expiry date of “06/2022” and one bottle of ProClean ABHR with no expiry date. The containers were not used by any resident, staff or visitor in the home. The home replaced the ABHR immediately when it was brought to their attention and checked the other containers of ABHR.

Sources: observations and staff interviews.

Date Remedy Implemented: August 8, 2022
[563]

WRITTEN NOTIFICATION [TRAINING]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 [s. 82 (2) 9]

The licensee has failed to ensure that no staff at the home would perform their responsibilities before receiving training in infection prevention and control (IPAC). The training required under section 82 of the FLTCA must be provided within one week for IPAC.

Rationale and Summary
The Personal Support Worker (PSW) was hired after April 11, 2022. The Surge Education Status Report – 2022 for a PSW documented the “IPAC Education January 2021” assigned to all staff was not completed and the “IPAC Chapter 1 Fundamentals (June 2016)” assigned for all staff was not listed for the PSW and therefore was not completed.

The Resident Care Coordinator (RCC) was hired after April 11, 2022. The Surge Education Status Report – 2022 for the RCC documented the “IPAC education January 2021” was completed in June 2022, the “N95 Mask - How to Wear | N95 Respirator Nursing Skill Tutorial” was completed in May 2022, and the “Infection Prevention and Control Competencies (2)” assigned to registered staff was not listed for the RCC and therefore was not completed.

The IPAC Lead stated the PSW and the RCC’s education for “all staff” was assigned differently on Surge Learning. The IPAC Lead stated the Surge report would identify a percentage of courses completed, but not that the appropriate courses were assigned according to the staff member’s role.

The Director of Care (DOC) stated the IPAC Chapter 1 Fundamentals was not listed as a course requirement and should have been for the RCC. The DOC verified the PSW did not complete the IPAC Education January 2021 course or the N95 Mask training and should have prior to performing their responsibilities.

Sources: Surge Education Status Report – 2022, and staff interviews.

[563]

WRITTEN NOTIFICATION [SPECIFIC DUTIES RE CLEANLINESS AND REPAIR]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 [s. 19 (2)(a)]

The licensee has failed to ensure that the home, furnishings and equipment were kept clean.

Rationale and Summary
The ceiling exhaust fan in the B side tub room was blocked with dust preventing appropriate airflow. Wall mounted fans in the hallways had a build up of dust present on the back and some dust was flying out from the front.

The housekeeper stated the maintenance team were responsible for cleaning the wall mounted fans and exhaust fans.

The Environmental Service Manager said it was the maintenance team who cleaned the air vents. The fans were installed in May 2022 and were not cleaned since. In June 2022 they cleaned the air vents but they probably missed the tub vents.

The Executive Director stated the vents and fans should have been cleaned.

Sources: Observations and staff interviews.
[523]

WRITTEN NOTIFICATION [POLICIES AND RECORDS]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 11 (1) (a)]

The licensee has failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation (O. Reg) 246/22, s. 23. (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices.

O. Reg. 246/22. s. 23. (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,

(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2) and (3) reaches 26 degrees Celsius (*C) or above, for the remainder of the day and the following day.

Rationale and Summary
The Heat Related Illness Prevention and Management Plan – Resident policy last revised July 2021, included under section "Summertime practices: there are 2 levels of interventions: a heat stress intervention alert (humidex 30-39). B. heat stress emergency alert (humidex 40-45)."

Registered nursing staff members said the heat related illness management plan would be initiated if the humidex was above 30.

The Executive Director (ED) said the heat related illness management would be initiated when the air temperature was above 26 degrees. The ED said the humidex level was specific for the health and safety for employees, but this was not specified in the resident policies. The ED said this policy was not in compliance with the regulations.

On August 17, 2022, the ED provided Inspector #523 with a revised heat related illness policy.

Sources: Heat Related Illness Prevention and Management Plan – Resident policy and staff interviews.
[523]

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 20 (a)]

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily accessed and used by residents, staff and visitors at all times.

Rationale and Summary
The Executive Director (ED) was present during the following observations:
- First room: call bell string that would activate the resident-staff communication and response system was not attached to any switch that would activate the system. In between the resident beds there were two switches. Inspector #523 and the ED pulled down one switch and the system did not activate and pulling down the other switch did activate the system.
- Second room: call bell strings were attached to one of the two switches on the wall. Inspector #523 and the ED pulled down the switch but the resident-staff communication and response system was not activated.

The ED stated an external vendor assessed the system and found that only one of the two switches would activate the resident-staff communication and response system. Residents, staff or visitors would not be able to access the system if the string was attached to the deactivated switch. The ED stated they were going to add labels to the switches to ensure call bell strings were attached to the active switch.

Sources: Observations and staff interviews.
[523]

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 20 (g)]

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was audible to staff.

Rationale and Summary
A resident room was observed and the Executive Director (ED) was shown that when the resident-staff communication and response system was activated in the room and bathroom it was not audible. Inspector #523 and the ED observed the light was flashing in the hallway above the resident door and on the switch board by the nursing station, but there was no sound to alert that it was activated. Staff present at the nursing station informed the ED that most of the call bells were not audible.

Inspector #523 and the ED were in the B wing tub room, Inspector #523 activated the call bell and it was not audible.

The ED stated an external vendor had assessed the resident-staff communication and response system, and they found two speakers in the hallway were covered with duct tape. The tape was removed and the system was then audible.

The Environmental Service Manager (ESM) stated it was not the first time staff had covered the speakers with duct tape. The ESM previously found an incontinent product wrapped around the speakers. The ESM said they conducted quarterly audits on the call bells and the last one was done in April 2022.

Sources: Observations and staff interviews.
[523]

WRITTEN NOTIFICATION [COOLING REQUIREMENTS]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 23 (7)]

The licensee has failed to ensure on or before June 22, 2022, all resident bedrooms were served by air conditioning.

Rationale and Summary
Observations during the inspection showed that some resident rooms were not served by an air conditioner.

The Executive Director (ED) stated the home did not yet install air conditioners in every resident room. The home had purchased the units, but they were delayed in shipping. The ED provided proof of purchase.

Sources: staff interviews
[523]

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 24. (2) 3]

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in every designated cooling area, if there are any in the home.

Rationale and Summary
The housekeepers said there were two designated cooling areas in each resident home area. They measured and documented the air temperatures in one common or designated cooling area on each resident home area but not each designated cooling area.

The Executive Director (ED) reviewed the Ambient Air Temperature Log sheets and found that staff were not measuring and documenting the air temperature in every designated cooling area as required.

Sources: Ambient Air Temperature Logs and staff interviews.
[523]

WRITTEN NOTIFICATION [AIR TEMPERATURE]

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

Non-compliance with: O. Reg. 246/22 [s. 24 (3)]

The licensee has failed to ensure that the temperature required to be measured was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
The Executive Director (ED) reviewed the Ambient Air Temperature Logs provided from June 1, 2022, to Aug 9, 2022, and there were several missing measurements. The ED stated the air temperatures were not being taken and documented as required.

Sources: Ambient Air Temperature Logs and staff interviews.
[523]

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) 4]

The licensee has failed to keep a written record of the organized program of Falls Prevention and Management, Pain Management and Skin and Wound Care evaluations that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The Executive Director, the Pain Management Program Lead, and the Falls Prevention and Skin & Wound Program Lead stated the home did not have a written record of the annual evaluation of the programs that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Sources: Staff interviews.
[523]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 102 (7) 3]

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the following responsibility of overseeing the delivery of IPAC education to all staff, caregivers, volunteers, visitors and residents.

Rationale and Summary
The IPAC Lead stated the Executive Director was overseeing the IPAC education delivered through Surge Learning online. The IPAC lead stated they were not instructed to oversee the delivery of Surge IPAC education and did not over see the completion of Surge Learning of IPAC education and there was IPAC education not completed by staff hired after April 11, 2022, and they were unaware of this.

The Executive Director (ED) stated they were responsible for overseeing the completion of IPAC training in Surge for orientation and monitored the annual the training. The ED then communicates completion to managers. The Director of Care verified that the IPAC lead was not overseeing the delivery of IPAC education.

Sources: Surge Education Status Report – 2022, and staff interviews.
[563]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 102 (7) 9]

The licensee has failed to ensure that the designated infection prevention and control (IPAC) lead carried out the following responsibility of reviewing any monthly screening results collected by the licensee to determine whether any action was required.

Rationale and Summary
The IPAC Lead stated they were not reviewing any monthly screening results to determine whether any action was required. There was risk that the action required was not implemented because the monthly screening results were not reviewed.

Sources: Interview with the IPAC Lead.
[563]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 102 (10)]

The licensee has failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Subsection (9):
The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary
The IPAC Lead verified that the surveillance information gathered was not reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. The IPAC Lead stated it was not completed at the home level or by head office. The IPAC Lead did not know a monthly review of symptoms indicating the presence of infection in residents was a requirement and verified there was no monthly surveillance data trend analysis for the last two months.

Daily Infection Control Surveillance Policy Long-Term Care (LTC) stated, “9. The IPAC Lead will track the number of infections in each of the categories monthly and analyze for trends.” IPAC Lead verified they did not track infections monthly.

Sources: Daily Infection Control Surveillance Policy, and staff interviews.
[563]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

WRITTEN NOTIFICATION [MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS]

NC#015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 147 (3)(a)]

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary
There was no previous written record of a quarterly review of the medication incidents between January and March 2022, and the quarterly review between April and June 2022 had minimal information documented and there was no written record of the actions taken or planned and by who.

The Professional Advisory Committee dated April 28, 2022, documented “see Medication Error Analysis section for reference” of the summarized medication errors from previous quarter. The Medication Error Analysis documented “dose omission is trending this quarter” for January to March 2022 and the actions taken included “education to all staff” and the persons responsible were “all staff” with no anticipated completion date. The Medication Error Analysis documented “dose omission and nurses not checking/completing orders correctly” for April to June 2022 with no documentation of the actions taken.

The Resident Care Coordinator (RCC) stated they went back and documented the information identified as part of the medication incident quarterly review between April and June 2022 and stated there was no analysis of the medication incidents between January and March 2022. The RCC stated the Medication Error Analysis was documentation from the medication incident reports, inputting information but not analyzing it for trends or if changes and improvements were identified. The RCC verified that actions taken were absent from the review when dose omission and nurse error was a trend between April and June 2022. There was missing information as part of the review and other information was minimal where an analysis of the medication incidents would be very difficult in order to identify changes or improvements to reduce future medication incidents. The quarterly review did not identify the medication, the resident, or the circumstances of the incident to determine changes or improvements.

Sources: Medication Error Analysis, Professional Advisory Committee dated April 28, 2022, CareRx Pharmacy Policy 9-1 Medication Incident Reporting last revised 06/20, and staff interviews.
[563]

WRITTEN NOTIFICATION [ORIENTATION]

NC#016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 259 (2)(c)]

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC) required included signs and symptoms of infectious diseases.

Rationale and Summary
The IPAC Lead stated they were unsure if all new hires as of April 11, 2022, were required to complete education in signs and symptoms of infectious diseases but identified COVID was a part of the PowerPoint for orientation.

The Executive Director (ED) stated the IPAC education that was required for all new hires after April 11, 2022, for the signs and symptoms of infectious diseases and the handling and disposing of biological and clinical waste was now being added to the curriculum for IPAC training. The Director of Care (DOC) verified that the Personal Support Worker and the Resident Care Coordinator hired after April 11, 2022 would not have received it.

Sources: Surge Education Status Report – 2022, IPAC Education for Surge Learning and staff interviews.
[563]

WRITTEN NOTIFICATION [ORIENTATION]

NC#017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 [s. 259 (2)(h)]

The licensee has failed to ensure that the training for staff in infection prevention and control (IPAC) required included handling and disposing of biological and clinical waste.

Rationale and Summary
The IPAC Lead stated they were unsure if all new hires as of April 11, 2022, were required to complete education in disposing of biological and clinical waste.

On September 12, 2022, the Executive Director (ED) stated the IPAC education for the handling and disposing of biological and clinical waste that was required for all new hires after April 11, 2022, was now being added to the curriculum for IPAC training. The Director of Care (DOC) verified that the Personal Support Worker and the Resident Care Coordinator (RCC) hired after April 11, 2022, would not have received it.

The RCC stated they did not receive education related to the handling and disposing of biological and clinical waste but did have training in the disposal of used personal protective equipment.

Sources: Surge Education Status Report – 2022, IPAC Education for Surge Learning and staff interviews.
[563]

COMPLIANCE ORDER [CO #001, DR #001] [SAFE & SECURE]

NC#018 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 [s. 5]

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with [s. 5]

Specifically, the licensee must:
a) Ensure each paper towel dispenser is within reach of the sink in areas of the home where residents are mobile.
b) Ensure all floor tiles in recreation room A1 are fixed and not peeling off.
c) Ensure the mold in recreation room A1 and adjacent shower room is removed, the cause of the mold determined and the appropriate repairs have been made.

Grounds

Non-compliance with: FLTCA, 2021 [s. 5]

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary
A) A Personal Support Worker (PSW) was observed washing hands at the sink in the A1 dining room near the entrance to the dining room. The PSW was walking with wet dripping hands past the snack cart, moved the other cart away from the wall with their foot to gain access to the paper towel dispenser located at the servery window, dried their hands and returned to the sink faucet to shut off the water with the used paper towel. The distance was approximately 6-8 feet between the sink and where the staff had to walk to access paper towels. The Restorative Aide (RA) was also observed performing hand hygiene at the sink and there was a trail of dripped water on the floor that was a potential risk to residents and staff walking in this area. The same set up was identified in the A2 dining room. The RA was then observed sitting with a resident doing exercises in the A1 Recreation Room, and the same concern was noted related to the distance between the sink and the paper towel dispenser. The RA washed their hands and walked past the front of a resident sitting with their back to the window, hands dripping water on the floor and retrieved paper towel and back over the wet floor to shut off the taps.

The Executive Director (ED) viewed the distance between the sink and paper towel for staff hand hygiene during a meal service in A1 and verified there was potential risk to staff and

mobile residents when there was continuous hand hygiene performed during a meal service and dripped water between the sink and towel dispenser.

There were mobile residents walking in and out of the A1 and A2 dining rooms and a resident was observed doing exercises in the A1 Recreation Room used for rehabilitation exercises. There was potential risk of falling of mobile residents when the floor was wet during dining service and exercise programs.

B) Observations during the inspection showed vinyl floor tiles in the A1 recreation room were peeling off and tiles were taped down. One tile was noted to be missing; the floor was uneven and posed a tripping hazard to staff and residents.

Observations in the A1 recreation room showed that wallpaper was peeling off the wall revealing a black mold like substance on the wall. This wall was shared by the shower room. Observations in the shower room showed black mold like substance was on the ceiling of the shower room on one side and the other side appeared repaired.

The Restorative Aide stated they reported to the Executive Director (ED) that the floor was peeling off in March 2022 and stated the peeling floor created a risk to the rehab residents using that room. The RA also reported that they informed the ED the previous day about the wall disrepair.

The ED stated the Environmental Service Manager knew about the floor in the AI recreation room and had obtained a quote for installation, and there were delays due to outbreaks in the home. The ED said the mold on the wall was high risk for the residents and staff, therefore the room would be closed for the restoration of the wall.

There was a potential for high risk to mobile residents related to the tripping hazard and mold presence on the wall.

Sources: observations and staff interviews.
[563, 523]

This order must be complied with by November 28, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#001]

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 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

- Order #001 of Inspection #2020_722630_0002, LTCHA, 2007 s. 5

This is the first time an AMP 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.*

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

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
email: 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.