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

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Original Public Report

Report Issue Date October 24, 2022
Inspection Number [2022_1013_0001]
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royale Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Case Manor Care Community-Bobcaygeon

Lead Inspector
Sami Jarour (570)

Additional Inspector(s)
Nicole Jarvis (741831)

Inspector Digital Signature
Sami Jarour
Digitally signed by Sami Jarour
Date: 2022.10.26 09:48:21 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 29, 30, 31, September 1, 2, 6, 7, 8, 12, 13, 14 and 15, 2022.

The following intake(s) were inspected:
- Intake #005179-22, related to an outbreak.
- Intake #006194-22, related to an outbreak.
- Intake #008637-22, related to an allegation of abuse.
- Intake #010482-22, related to an unexpected death of a resident.
- Intake #004013-22, Complaint related to concerns with no hot water.
- Intake #010056-22, Complaint related to incontinent products.
- Intake #015540-22, Complaint related to IPAC practices and food production.
- Intake #005267-22, Follow up to Compliance Order (CO) #001 issued on March 15, 2022, under Inspection Report #2021_523461_0004 related to O. Reg 79/10, s. 229. (4) with a compliance due date of April 15, 2022.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229. (4)	2021_523461_0004	001	570

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [SAFE AND SECURE HOME]

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

Non-compliance with: O. Reg. 246/22 s. 12 (1) 3.

The licensee has failed to ensure all doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary

A non-residential storage area was observed left unlocked and unattended. The storage room contained incontinent products and disinfectant. Staff stated that the storage area must always be locked.

By not locking the doors to storage areas with hazardous martial could put residents accessing those areas at risk of harm.

Sources: Observations of the storage room and staff interviews. [741831]

WRITTEN NOTIFICATION [OBTAINING AND KEEPING DRUGS]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.138 (1)(a)(ii)

The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

Rationale and Summary

During the inspection, it was observed that all medicated treatment cream storage containers were easily accessible and unlocked.

During an observation of a medication pass, a registered practical nurse (RPN) left the medication cart unattended and unlocked throughout the medication pass.

The Director of Care (DOC) stated that all drugs including treatment creams requires to be locked and secured when left unattended.

By not adhering to the regulations of safe storage of drugs, there was an increased risk to residents accessing medication that could cause a negative adverse health status.

Sources: Observation of Medication pass and treatment cream storage, interviews with RPN and DOC. [741831]

WRITTEN NOTIFICATION [REQUIRED PROGRAMS]

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

Non-compliance with: O. Reg. 246/22 s. 53 (1) 3.

The licensee has failed to comply with their policies, procedures, and processes within the Continence Care program.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to have a continence care and bowel management program and ensure it is complied with.

Specifically, the home did not comply with the licensee's policy Continence Program – Products, VII-D-10.20 (Last Revised: 04/2019) which is part of the licensee's Continence Care and Bowel Management Program.

Rationale and Summary

A complaint was submitted to the MLTC indicating that the resident was obligated to purchase their own care products.

The licensee's policy states that when a resident wishes to purchase their own care product it will be documented in the resident record, the reasons as to why the resident/ SDM deems the products offered by the care community to be inadequate to meeting the resident's needs.

Inspector#741831 completed a resident's record review and no documentation was provided to explain the reason why the resident was providing their own care products.

The Director of Care (DOC) confirmed that staff must document the reasoning why the resident wishes to purchase their own care products. The DOC was unable to provide this documentation to the inspector.

By not implementing the home's continence care program could increase the risk of residents not being provided with an appropriate care product.

Sources: Policy - Continence Program – Products, VII-D-10.20 (Last Revised: 04/2019), Staff interviews (PSW, DOC), Resident Record Review. [741831]

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

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

Non-compliance with: O. Reg. 79/10, s. 107. (1) 5.

The licensee has failed to ensure that the Director was immediately informed of COVID-19 and enteric outbreaks in the home.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director one day after the public health unit declared an outbreak at the home. A second CIS report was submitted to the Director one day after the public health unit declared another outbreak at the home.

The Director of Care (DOC) acknowledged the CIS reports were submitted late and that outbreaks should be immediately reported to the Director.

Sources: CIS reports, interview with the DOC. [570]

WRITTEN NOTIFICATION [ACCOMMODATION SERVICES]

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

Non-compliance with: O. Reg. 246/22 s. 96 (2) (k).

The licensee has failed to ensure that procedures were implemented to monitor the water temperature once per shift in random locations where residents had access to hot water when a computerized system to monitor the hot water was not in use.

Rationale and Summary

The licensee does not have a computerized water monitoring system. According to the home's Water Temperature Monitoring policy (VII-H-10.50; revised 04/2019), the temperature of the hot water will be monitored daily once per shift in random locations where residents have access to hot water.

The Water Temperature Monitoring Records for the months of May, June and July of 2022 were reviewed and revealed that water temperatures were recorded once during the night shift.

The Director of Environmental Services stated that water temperature was not monitored at the home every shift and the nurses monitored water temperature at night.

There was a potential risk of scalding to residents due to staff not implementing their hot water monitoring procedures.

Sources: Water Temperature Monitoring Records, Water Temperature Monitoring policy (VII-H-10.50; revised 04/2019), interview with The Director of Environmental Services. [570]

WRITTEN NOTIFICATION [ACCOMMODATION SERVICES]

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

Non-compliance with: O. Reg. 79/10 s. 90 (1) (i).

The licensee has failed to ensure the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

Rationale and Summary

A complaint was submitted to the MLTC indicating that the home had no hot water.

The Director of Environmental Services provided inspector #570 with water temperature readings taken at the source (boiler room) for the month of February 2022. The recorded temperatures indicated the temperature at the source (boiler room) was below 40 degrees Celsius on February 10, 22 and 24, 2022, with temperature range of 35.5 to 39.4 degrees Celsius. No temperatures were recorded on February 5, 6, 12, 13, 19, 20, 27, 2022.

According to the home's Water Temperature Monitoring policy (VII-H-10.50; revised 04/2019), the temperature of the hot water serving all bathtubs, showers, and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed 49 degrees Celsius.

The Director of Environmental Services stated that the water temperature was fluctuating and recorded below 40 degrees from February 15, 2022, through March 8, 2022. Water temperature taken after the mixing valve will drop a couple of degrees when reaching the tubs.

By not maintaining appropriate water temperature for bathing could disrupt residents bathing and result in an uncomfortable bathing experience for the residents.

Sources: Water temperature records for February 2022, Water Temperature Monitoring policy (VII-H-10.50; revised 04/2019) and interview with the Director of Environmental Services. [570]

WRITTEN NOTIFICATION [ACCOMMODATION SERVICES]

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

Non-compliance with: O. Reg. 79/10 s. 92.(1)(a)

The licensee has failed to ensure that the designated lead for each of the housekeeping, laundry services and maintenance services programs, had a post-secondary degree or diploma.

Rationale and Summary

The Director of Environmental Services (DES) stated that they were the designated lead for housekeeping, laundry and maintenance services programs. The DES stated they did not have a post-secondary degree or diploma.

The interim Executive Director (ED) indicated they were not involved in hiring the DES and that their file did not include a copy of any post-secondary degree or diploma.

Sources: interviews with the Director of Environmental Services and the interim executive director. [570]

WRITTEN NOTIFICATION [PREVENTION OF ABUSE AND NEGLECT]

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

Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse.

O. Reg. 246/22, s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care, indicated that a resident was struck by coresident and sustained an injury. The resident was frightened that coresident would come in again to their room.

A review of progress notes indicated the resident reported to a Registered Practical Nurse (RPN) that a coresident often enter their room and that they were terrified of the coresident as they were rude to them and verbally aggressive. The resident stated they have not been able to sleep due to fear from coresident. The progress notes review did not indicate any new interventions put in place to protect the resident from abuse.

An interview with the RPN indicated no new interventions were put in place when a resident stated they were terrified of coresident. RPN indicated a specified intervention could have been implemented but that was not done until after the incident.

An interview with the Director of Care (DOC) indicated the RPN should have contacted the manager on call and BSO should have been notified when the resident expressed concerns of being frightened so that further intervention could have been put in place.

The home failed to protect a resident from abuse that resulted in an injury by not having new interventions put in place when the resident expressed concerns of being frightened of a coresident.

Sources: CIS report, review of resident's progress notes, interviews with RPN and the DOC. [570]

WRITTEN NOTIFICATION [NUTRITIONAL CARE AND HYDRATION PROGRAMS]

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

Non-compliance with O. Reg. 246/22 s. 79 (1) 5

The licensee has failed to ensure that meals were served at both safe and palatable temperatures for the residents.

Rationale and Summary:

A complaint was submitted to the MLTC related to dietary services at the home.

During a meal service a Care Support Assistant (CSA) did not take temperatures of cold items.

A review of the food temperature records from revealed that food temperature was not consistently taken prior to serving residents on multiple dates.

A review of the kitchen production reports, indicated the cook-end temperatures were not recorded for breakfast food items and the temperature was not consistently taken for lunch and dinner food items.

According to the home's Food Temperatures – Point of Service policy (XXIII-H-10.30; revised 06/2019), the food temperature will be taken at point of service prior to serving food to residents. Food temperatures must be minimum of 140 F (60 C) for hot food and no more than 40 F (4 C) for cold food.

The Director of Dietary Services (DDS) indicated that staff should be taking temperature at production by the cook and prior to serving residents by dietary aides. The DDS acknowledged that food temperature was not consistently taken on production and prior to serving residents and acknowledged the gaps in recordings of food temperature on multiple dates.

By not ensuring meals were served to residents at safe and palatable temperatures, there could be negative effects on the residents, such as decreased intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

Sources: Observations; food temperature records, kitchen production reports, Food Temperatures – Point of Service policy (XXIII-H-10.30; revised 06/2019); interviews with CSA and the Director of Dietary Services. [570]

WRITTEN NOTIFICATION [NUTRITIONAL CARE AND HYDRATION PROGRAMS]

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

Non-compliance with: O. Reg. 246/22 s. 74 (2) a

The licensee has failed to comply with their policies, procedures and processes within the organized program of nutritional care and dietary services specific to monitoring of food temperatures at production and at point of service.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to have a nutrition and hydration program and ensure it is complied with.

Specifically, staff did not comply with the licensee's policy Food Temperatures – Point of Service policy (XXIII-H-10.30; revised 06/2019). According to the home's Food Temperatures – Point of Service policy (XXIII-H-10.30; revised 06/2019), the food temperature will be taken at point of service prior to serving food to residents. Food temperatures must be minimum of 140 F (60 C) for hot food and no more than 40 F (4 C) for cold food. The dietary team will sanitize the pocket thermometer with an alcohol swab or recommended food safe sanitizer prior to taking the temperature of each food item.

Rationale and Summary

During a meal service, a Care Support Assistant (CSA) was observed wiping a thermometer with their apron prior to inserting the thermometer into food. The CSA rinsed the thermometer with running water prior to taking temperatures of remaining foods. The CSA did not use alcohol swabs to sanitize the thermometer as directed by the home's policy. The CSA confirmed they used their apron to clean the thermometer and did not use alcohol swab.

The Director of Dietary Services (DDS) stated cleaning the thermometer with apron was not appropriate and that the CSA should have used alcohol swabs to clean the thermometer.

By not properly cleaning and sanitizing the thermometer used to take food temperatures could result in cross contamination and put residents at risk of allergic reactions.

Sources: Observations, Food Temperatures – Point of Service policy (XXIII-H-10.30; revised 06/2019); interviews with CSA and the Director of Dietary Services. [570]

WRITTEN NOTIFICATION [COMMUNICATION AND RESPONSE SYSTEM]

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 20(d)

The licensee has failed to ensure that the call bell was available at the toilet in a resident's room.

Rationale and Summary

Inspectors observed bathroom of a resident's room did not have a call bell at the toilet. No other alternative was in place for the resident or others to alert staff if assistance was needed.

The Director of Environmental Services stated that there was no call bell in the bathroom as the call bell was pulled out and the wires broke. A replacement call bell has been ordered.

Not having a call bell at the toilet could put residents at risk of harm when unable to alert staff if assistance was needed.

Sources: Inspectors' observations; interview The Director of Environmental Services. [570]

COMPLIANCE ORDER [CO#001] [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#012 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.102.(7)11

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.102.(7)11 of O. Reg. 246/22

Specifically, the Licensee must:

1. Ensure hand hygiene agents are available at the point-of care with 70-90% Alcohol content.
2. Remove all expired hand hygiene agents from circulation in the home.
3. Develop and implement an auditing process to ensure hand hygiene agents dispensers at the point-of care in all areas accessible to residents are functional. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds

Non-compliance with: O. Reg. 246/22 s. 102 (7) 11

The licensee has failed to ensure that their hand hygiene program included access to hand hygiene agents at the point of care with 70-90% Alcohol content.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that 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.

Rationale and Summary:

Observations of the IPAC practices related to residents' hand hygiene identified that hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) were not easily accessible at point-of care in multiple residents' rooms.

Expired hand sanitizer dispensers were found in use in the activity room on the third floor and in the dining room on the second floor. Expired four small pocket hand sanitizer dispensers in the drawer of personal protective equipment (PPE) caddy by two adjacent residents' rooms.

A wall-mounted hand sanitizer dispenser by the stairwell on the second floor had no label and no expiry date of the hand sanitizer cartridge. The Director of Environmental Services stated that the dispenser has a refill cartridge and those were expired.

In a resident's room identified under contact precautions, a small hand sanitizer dispenser on PPE caddy was expired and two hand sanitizers pump dispensers were observed to be expired on July 2022; the wall-mounted hand sanitizer dispenser at point of care was non-functional and the ABHR agent had an expiration date of Feb 2016.

Multiple residents' rooms had wall mounted point-of care hand sanitizer dispensers that were observed to be non-functional in all residents' home areas. Multiple dispensers had ABHR agents' cartridges that were observed to be expired with expiration dates: November 2015; Feb 2016; March 2017, April 2021; June 2021; April 2022, July 2022.

Several mounted hand sanitizer dispensers at the point of care in residents' rooms had no cartridges with no ABHR available at the point of care in five residents' rooms. Several residents' rooms observed with no ABHR or hand hygiene agents available at the point-of care in other five residents' rooms.

Four PSW staff and RPN confirmed they don't use the hand sanitizer dispensers at point-of care in residents' rooms as they were non-functional. They indicated they perform hand hygiene before entering residents' rooms and when leaving residents' rooms using the wall-mounted hand sanitizer dispensers in the hallway outside of residents' rooms.

The Director of Care stated that expired hand hygiene agents should not be used at the home and that hand hygiene agents should be available at point-of care.

Due to the home not ensuring access to 70-90% Alcohol Based Hand Rub (ABHR) at point-of care, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents including the COVID-19 virus.

Sources: inspector's observation, IPAC Standards and interviews with PSWs, RPN and the DOC. [570]

This order must be complied with by November 24, 2022

COMPLIANCE ORDER [CO#002] [ACCOMMODATION SERVICES]

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 93 (2)(b)(iii)

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. 93 (2)(b)(iii) of O. Reg. 246/22

Specifically, the Licensee must:

1. Review and update Housekeeping Cleaning Frequency Schedule-XII-D-10.40 polices (a) and (b) in accordance with current best practice.
2. Train housekeeping staff and any other staff responsible for cleaning high touch surfaces on the newly updated Housekeeping Cleaning Frequency Schedules.
3. Develop and implement an auditing process to ensure high touch surfaces are cleaned and disinfected at least once per day and more frequently in outbreak areas. Keep a documented record of the audits completed and make available for Inspectors, upon request.

Grounds

Non-compliance with O. Reg. 246/22 s. 93 (2)(b)(iii)

The licensee has failed to ensure handrails were cleaned in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings, dated July 16, 2021, directs to clean and disinfect high touch or frequently touched surfaces at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Rationale and Summary

During the inspection, Inspectors observed housekeeping staff cleaning high touch surfaces inside residents' rooms. No cleaning was observed done to handrails in hallways.

The home's policy "Housekeeping Cleaning Frequency Schedule-Outbreak – XII-D-10.40(b)- dated July 2020" indicates daily frequency of cleaning of steps and handrails. The home's policy "Housekeeping Cleaning Frequency Schedule-XII-D-10.40(a)- dated July 2020" indicates weekly frequency of cleaning of handrails and the home's policy. The home's policy was not accordance with best practice relating to environmental cleaning in healthcare settings.

A housekeeper stated they did not do high touch surface cleaning of the handrails in hallways for few days. Two housekeepers stated that high touch surface cleaning is not done when short staffed.

The IPAC lead stated the home would utilize Care Support Assistants CSA for the cleaning and disinfecting frequently touched contact surfaces once a day in the evening due to staffing in the housekeeping department.

A Care Support Assistant (CSA) stated they worked on evening shifts and that they have not done any cleaning or disinfecting of handrails as they were assisting in the dietary department.

The Director of Environmental Services (DES) acknowledged the handrails are not cleaned or disinfected daily as there had been occasions when the home was short staffed in the housekeeping department. The DES acknowledged that the home's policy "Housekeeping Cleaning Frequency Schedule-Outbreak – XII-D-10.40(b)" and "Housekeeping Cleaning Frequency Schedule-XII-D-10.40(a)" dated July 2020" did not reflect the requirement of daily cleaning of handrails and the twice daily cleaning of handrails during an outbreak situation.

Failure to clean and disinfect high touch surfaces including handrails could contribute to the spread of infectious agents including COVID-19.

Sources: Inspector's observations; The Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings, dated July 16, 2021, Housekeeping Cleaning Frequency Schedule-Outbreak – XII-D-10.40(b) and Housekeeping Cleaning Frequency Schedule-XII-D-10.40(a)- dated July 2020; interviews with Housekeepers, CSA, IPAC lead, and Director of Environmental services. [570].

This order must be complied with by November 24, 2022

COMPLIANCE ORDER [CO#003] [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#014 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

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.102 (2) (b) of O. Reg 246/22.

Specifically, the Licensee must:

1. Educate PSW staff and any other person who conducts screening for staff and visitors to the home on the appropriate selection, application, removal, and disposal of Personal protective Equipment (PPE) for screening.
2. Conduct daily audits for two weeks of the screening activities. Keep a documented record of the audits completed and make available for Inspectors, upon request.
3. Provide on the spot education to staff not adhering with appropriate IPAC measures during screening activities. Keep a documented record of the education provided and make available for Inspectors, upon request.

Grounds

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, the licensee did not ensure that the proper use of PPE, including appropriate selection, application, removal, and disposal, were followed in the IPAC program as required by Additional Requirement 9.1 Routine Practices (d) under the Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Rationale and Summary

On an identified date, a PSW staff was observed on two occasions completing a rapid test without the appropriate application of Personal Protective Equipment (PPE). The PSW did not apply eye protection and did not use gloves.

The PSW stated that they sometimes forget to apply the eye protection and change their gloves while completing the screening activities, including the rapid antigen test. The PSW stated that they know the use of the appropriate Personal Protective Equipment will protect themselves and others.

According to the IPAC Lead, the screener requires to wear eye protection, gloves, mask, and a gown while completing screening activities.

By conducting improper PPE selection, application, removal, and disposal, there was a risk of the transmission of infectious agents including COVID-19 to residents, visitors, and staff.

Sources: Observations of IPAC practices at the home and interviews with PSW and the IPAC lead. [741831]

This order must be complied with by November 24, 2022

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:

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.