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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 6, 2023
Original Report Issue Date: May 8, 2023
Inspection Number: 2023-1054-0003 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Guildwood,Scarborough

Amended By	**Inspector who Amended Digital Signature**
Rodolfo Ramon (704757)	Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2023.06.21 15:44:50 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This public inspection report has been revised to reflect a change in the compliance due date. The inspection #2023-1054-0003 was completed on April 24, 2023.

Ontario

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Long Term Care Home and City: Extendicare Guildwood, Scarborough	
Lead Inspector Rodolfo Ramon (704757)	**Additional Inspector(s)** Kehinde Sangill (741670) Atala Katel (000705)
Amended By Rodolfo Ramon (704757)	**Inspector who Amended Digital Signature** Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2023.06.21 15:45:44 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This public inspection report has been revised to reflect a change in the compliance due date. The inspection #2023-1054-0003 was completed on April 24, 2023.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 5, 6, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 2023

The following intake(s) were inspected:

- Intake: #00005891 - was related to abuse.
- Intake: #00008471 - was related to a fall with injury.
- Intake: #00011070 - was related to a medication incident.

- Intake: #00011444 - was related to abuse.
- Intake: #00015870 - was related to a complaint regarding falls prevention and management, 24-hour nursing care, doors in a home and housekeeping services.
- Intake: #00018057 - was related to neglect.
- Intake: #00018281 - was related to a complaint regarding alleged abuse and skin and wound care.
- Intake: #00084339 - was related to a complaint regarding alleged abuse, maintenance services, and bedtime and rest routines.

The following intake(s) were completed:

- Intake #00001559-22 - was related to a fall incident with injury.
- Intake #00021427-23 – was related to a fall incident with injury.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED 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)
Non compliance with: FLTCA, 2021, s. 6 (1) (a).

The licensee has failed to ensure that an intervention was included in a resident's plan of care.

Rationale and Summary
A device was observed on a resident's room. The device was not included in their written plan of care as an intervention.

Behaviour Support Ontario (BSO) Lead stated that the resident required the device to deter other residents from entering their room. The BSO lead acknowledged that the care plan should have been updated to include the intervention.

On April 20, 2023, the resident's care plan was updated.

Sources: Resident observations; the resident's care plan; interview with BSO Lead. [741670]
Date Remedy Implemented: April 20, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The resident's plan of care indicated they required an intervention to help the resident locate their room. During observations conducted by the inspector, this intervention was not in place. The BSO lead verified the intervention should have been in place.

Sources: The resident's care plan, observations, interview with the BSO lead.
[704757]
Date Remedy Implemented: April 24, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b).

The licensee has failed to ensure that nursing staff collaborated with the physiotherapist in the implementation of fall interventions for a resident.

Rationale and Summary
A resident sustained an injury as a result of a fall incident. A Review of the resident's health records indicated the resident had multiple falls over the previous six months. Before the fall incident, the

Physiotherapist (PT) made recommendations for fall prevention strategies to be implemented in the resident's plan of care. The resident's plan of care at the time of the incident did not include the PT's recommendations. The Personal Support Worker (PSW) and the Registered Nurse (RN) confirmed the fall interventions recommended by the PT were not in place at the time of the incident. The home's fall prevention and management lead confirmed that the resident was at risk of falls and that recommendations from the PT were not implemented.

Failure to collaborate in implementing fall interventions for the resident, may have contributed to a fall resulting in significant change in their health status.

Sources: The resident's health records, interviews with the PSW, RN and the Falls' Prevention lead.
[000705]

The licensee has failed to ensure that staff collaborated with each other in the development and implementation of the plan of the care for a resident.

Rationale and Summary
The RN received a telephone order from the physician regarding a medication prescription for a resident but failed to communicate to the physician that the medication was contraindicated for the resident. As a result, the resident experienced an adverse effect which required additional treatment resulting in significant change in their health. The RN confirmed that they did not review the resident's plan of care and did not communicate the contraindication to the physician when the telephone order was received.

Sources: The resident's health records, and interviews with the RN.
[000705]

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).

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

Rationale and Summary
Prior to the inspection, the resident's care plan was revised to include fall interventions. During the inspector's observations, it was observed that interventions were not in put in place. The student PSW, who provided care for the resident confirmed that the interventions were not implemented.

Sources: Observations, the resident's health records and interview with the student PSW.
[000705]

WRITTEN NOTIFICATION: ACCOMODATION SERVICES

NC #005 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 and equipment were kept clean and sanitary.

Rationale and Summary
The Long-Term Care Home (LTCH) failed to keep multiple areas of the home in clean and sanitary conditions.

During the inspection, the following were observed:
- accumulation of dirt on multiple areas of the home,
- accumulation of food particles in a dining room along the baseboards,
- black and brown stains on the backrest of portable commode chairs on the toilets of two resident rooms,
- dried food particles on the wall and the baseboard in the hallway, that was again observed on a second occasion during the inspection.

The Support Service Manager (SSM) acknowledged that the dirt, stains and food particles were accumulated over a period of multiple days.

Sources: Observations of the home; Interviews with Environmental Service Aide #110, a PSW, Support Service Manager (SSM) and other staff.
[741670]

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

Rationale and Summary
A resident reported concerns with their bedroom's cleanliness. The RPN verified that the resident had brought this to their attention.

During the inspection, the inspector observed the resident's bedroom in unsanitary condition on two separate days.

A PSW stated they were too busy with other residents. The Support Service Aide (SSA) and the PSW verified that the resident's room had not been cleaned on the day of the observation.

Failure to ensure the home, furnishings and equipment were kept clean and sanitary, may negatively impact residents' quality of life by failing to maintain a hygienic environment.

Sources: Observations of the resident's room; Interviews with the resident, Environmental Service Aide #115, PSWs #107, #111, #118, RPN #116 and other staff.
[741670]

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).

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A complaint was brought forward to the MLTC related to an inappropriate interaction between resident #001 and #003.

According to the licensee's policy titled Zero Tolerance of Abuse and Neglect Program policy, "Anyone who suspects abuse or neglect of a resident was required to notify management immediately". The RPN verified they were informed of the allegation and did not report it to anyone. Failure to comply with the policy to promote zero tolerance of abuse and neglect of residents placed resident #001 at risk of harm as it did not provide the licensee with the opportunity to investigate and formulate measures to prevent reoccurrence of similar incidents.

Sources: The licensee's policy Zero Tolerance of Abuse and Neglect Program #RC-02-01-01 last reviewed January 2022, the resident's progress notes, interview with the RPN.
[704757]

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) 2.

The licensee failed to immediately report an allegation of physical abuse of a resident #001 to the Director.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Act. pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

Rationale and Summary
A complaint was brought forward to the MLTC related to an inappropriate interaction between resident #001 and #003.

According to the home's policy, the licensee was required to inform the Director of any suspicion of abuse of a resident by anyone. A review of resident #001's progress notes indicated that an allegation of abuse of resident #001 by resident #003 was brought forward to the licensee.

According to DOC #120, the allegation was received on the same day and an investigation was initiated. DOC #120 verified that the Director was not informed.

Sources: The licensee's policy Critical Incident Reporting RC-09-01-06 Last Reviewed January 2022, resident #001's progress notes, interview with DOC #120.
[704757]

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #008 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 that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and that those doors were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During the inspection, the following areas in the home were left unlocked and unsupervised:
-The door was unlocked and ajar in the Personal Protective Equipment (PPE)/incontinent product storage room on a specific area of the home.
-The door was closed but unlocked as the keypad lock on the door was not working in the PPE utility room on a separate area of the home.
-The door was closed and was not equipped with a lock, in the soiled utility room.
-The door was ajar and unlocked in the medical supply storage room.

DOC #121 stated that the PPE utility room, PPE/Incontinent product storage room, Medical Supplies Storage Room, and soiled utility room were non-residential areas and should have been locked at all times for resident safety.

The home's policy listed utility rooms and storage room as non-residential areas and that doors leading to these areas must be locked to restrict unsupervised access.

Failure to secure non-residential areas put residents at risk of accessing unsupervised areas of the home.

Sources: Observations of the inspector; home's Door Surveillance and Secure Outdoors Area policy (OP-04-01-04, Last updated February 2020); interviews with DOC #121 and other staff.

[741670]

WRITTEN NOTIFICATION: FALLS PREVENTION & MANAGEMENT PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the falls prevention and management program was implemented.

Rationale and Summary
In accordance with O. Reg 246/22, s. 11 (b), the licensee was required to ensure that the written policy for falls prevention and management were complied with.

Speci6fically, staff did not comply with the licensee's Falls Prevention & Management policy when Falls Risk Assessments for a resident were not completed upon admission or after a fall that led to a significant change in health status.

According to the home's policy, staff were required to complete a fall risk assessment for all residents upon admission, after any fall with serious injury, and for residents with multiple falls. The resident sustained an injury as a result of a fall incident. The resident had five falls over the previous six months.

The home's falls lead indicated that the Falls Risk Assessment was used to screen risk of falls for residents and to create goals and strategies to mitigate those risks. The falls lead verified the assessment should have been completed for the resident.

Not completing the required assessment prevented the home from identifying mitigating risk factors, leading to multiple falls and injury to the resident.

Sources: The resident's health records, Falls Prevention & Management Program policy (RC-15-01-01, updated January 2022), interview with the falls' lead.

[000705]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g).

The licensee has failed to ensure that procedures were implemented to ensure that the temperature of the water serving all bathtubs and showers used by residents did not exceed 49 degrees Celsius.

Rationale and Summary
During a period of approximately three months, the water temperature taken at one of the boilers exceeded 49 degrees Celsius on multiple occasions.

There were no temperature checks conducted in resident showers to ensure that the temperature of hot water used by the residents did not exceed 49 degrees Celsius.

PSWs #100, #109 and #118 stated that they used their hands to test the water temperature in the shower room before giving residents a shower. PSWs #100 and #118 acknowledged they have not used a thermometer to measure water temperature in the shower.

DOC #121 stated that it was the responsibility of the nursing staff to check the shower water temperature before giving a shower to the residents.

DOC #121 and the Administrator acknowledged that the home did not take the temperature of hot water serving the showers. DOC #121 indicated that the temperature of the hot water serving the showers had not been taken since the summer of the year prior.

The home's policy required that care staff perform at a minimum three water temperature checks for each bath/shower, prior to immersing a resident into tub or giving a shower.
Staff's failure to take the temperature of hot water serving the shower put residents at risk for injury related to high water temperatures.

Sources: The home's Bathing, Showering and Water Temperature Monitoring policy (RC-06-01-02, Last reviewed January 2022), East Wing Building Checklist, Water Temperature Log; Interviews with PSWs #100, #109 and #118, DOC #121, the Administrator and other staff.

[741670]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i).

The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Rationale and Summary
A resident reported that they were unable to take showers because the water from the shower was too cold.

During the inspection, Support Service Manger #117 took the temperature of the water serving the shower in a resident home area. The water temperature was measured as below 40 degrees Celsius.

A review of the home's water temperature log showed that the temperature of water serving the residents were taken randomly at the hand basins in residents' washroom. During the month of April, the water temperature was below 40 degrees on multiple occasions. No records were available for water serving the showers.

PSWs #100, #109 and #118 stated that they used their hands to test the water temperature in the shower room before giving residents a shower. PSWs #100 and #118 acknowledged they did not use a thermometer to measure the water temperature in the shower.

DOC #121 stated that it was the responsibility of the nursing staff to check the temperature of the water serving the shower prior to resident use.

DOC #121 and the Administrator acknowledged that the home did not take the temperature of hot water serving the showers. DOC #121 indicated that the temperature of the hot water serving the shower had not been taken since the summer of the year prior.

The home's policy required care staff to ensure water temperature was between 38 degrees to 43 degrees Celsius, which did not meet the legislative requirement for water temperature.

The home's failure to develop and implement appropriate procedures to ensure water temperature met minimum legislative requirements may have negatively impacted residents' quality of life.

Sources: Observations of water temperature measurement; The home's Bathing, Showering and Water Temperature Monitoring policy (RC-06-01-02, Last reviewed January 2022), Water Temperature Log for April, 2023; Interviews with PSWs #100, #109 and #118, DOCs #121, the Administrator and other staff.

[741670]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #012 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 ensure that if the home is not using a computerized system to monitor the water temperature, the water temperatures were monitored once per shift in random locations where residents have access to hot water.

Rationale and Summary
The home's water temperature log showed that during the month of April, 2023, water temperature readings were only taken from hand basins in resident bathrooms on multiple occasions.

Support Service Manager #117 verified that the home was not using a computerized system to monitor the water temperature. The Manager also noted that the water temperature was measured once a day in the boiler room and two separate rooms in different areas of the home.

The home's policy required that the registered staff obtain the hot water temperature once per shift in random locations where residents have access to hot water.

Failure to obtain the temperature of hot water serving the shower at required intervals may have prevented identifying a pattern of low water temperature readings.

Sources: The home's Bathing, Showering and Water Temperature Monitoring policy (RC-06-01-02, Last reviewed January 2022), Water Temperature Log from April, 2023; Interviews with Support Service Manager #117 and other staff.

[741670]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The Licensee has failed to ensure that when unable to determine within one business day whether an incident that caused injury to a resident resulted in significant change in health condition, they informed the Director of the incident no later than three business days after the occurrence of the incident.

Rationale and Summary
The Resident had a fall with an injury. They were sent to the hospital for additional medical intervention and returned with a significant change in health condition. The home did not report the critical incident to the Director.

The BSO Lead verified that the resident experienced a significant change in heath status after the incident and acknowledged that the Director should have been informed.

DOC #121 stated that the home was initially unaware of the change to the resident's health condition. The DOC acknowledged that the home should have followed up with the health status of the resident in the hospital and submitted a critical incident report to the Ministry.

Sources: The resident's Clinical Records; interviews with BSO Lead and DOC #121. [741670]

WRITTEN NOTIFICATION: SECURITY OF DRUG SUPPLY

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 (1).

The licensee has failed to ensure the security of the drug supply, and that all areas where drugs were stored were kept locked at all times, when not in use.

Rationale and Summary
The medical supply storage room was discovered ajar and unlocked. The room was used to store drugs, and wound care products.

RN #101 stated that the door to the medical supply storage room had been broken for about a month and was not being locked.

DOC #121 acknowledged that the door leading to the room for drug storage should have been locked at all times.

Leaving the door to medical supply storage room ajar and unlocked placed residents at risk of harm for injury and/or accidental ingestion of drugs.

Sources: Observation of Medical Supply Storage room; interviews with RN #101, DOC #121 and other staff.

[741670]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
-List of residents who require redirection related to wandering behaviour on the identified resident home area.
-Strategies to protect identified wandering residents and any other residents from physical and sexual abuse.
-Education for staff who provide direct care on the identified resident home area on the policy for prevention for abuse and neglect, including the assessment of the ability for residents to consent to sexual interactions.
-Maintain a record of the education, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training.

Please submit the written plan for achieving compliance for inspection #2023-1054-0003 to Rodolfo Ramon (704757), LTC Homes Inspector, MLTC, by email by May 23, 2023.

Grounds
The licensee has failed to protect resident #001 from abuse by resident #003.

Rationale and Summary
A complaint was brought forward to the MLTC related to an inappropriate interaction between resident #001 and #003.

Section 2 of the Ontario Regulation 246/22, defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #003's progress notes indicated that on an identified date, resident #003 acted inappropriately in front of resident #001. The BSO lead verified that resident #001 did not have the capacity to consent to this interaction. Failure to protect resident #001 from #003 placed resident #001 at actual risk of harm.

Sources: Policy #RC-02-01-01 Zero Tolerance of Abuse and Neglect Program last reviewed January 2022, resident #003's progress notes, interview with the BSO lead.

[704757]

The licensee has failed to protect resident #005 from abuse by resident #004.

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the MLTC in regards to an altercation between resident #004 and resident #005.

On an identified date, an altercation took place between resident #004 and resident #005. As a result of the incident, resident #004 was transferred to the hospital for further assessment where it was determined resident #004 sustained an injury.

DOC #120 verified abuse of resident #004 by resident #005 was substantiated in the internal investigation. Failure to protect resident #004 from #005 resulted in actual harm to resident #005.

Sources: Resident #005's progress notes, the licensee's investigation notes, interview with DOC #120. [704757]

The licensee has failed to ensure that resident #009 was protected from sexual abuse by resident #010.

Rationale and Summary
Section 2 of the Ontario Regulation 246/22 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The MLTC received a CIS report related to an allegation of sexual abuse of resident #009. According to the CIS report, #010 touched resident #009 inappropriately.

Resident #010 had a history of responsive behaviours towards staff and residents.

PSW #125 stated that they witnessed resident #010 touching resident #009 inappropriately. PSWs #124, #125 and #127 stated that Resident #010 had responsive behaviours.

The BSO lead and DOC #121 acknowledged that resident #010 sexually abused resident #009 on October 14, 2022.

DOC #121 acknowledged that staff did not protect resident #009 from abuse by resident #010.

Sources: Critical Incident Report #2164-000046-22, resident #009 and #010's clinical records, home's investigation notes; interviews with PSW #124, #125, #127, BSO Lead, DOC #121 and other staff.

[741670]

This order must be complied with by July 4, 2023.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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 2021_595110_0006, LCTHA s. 19(1).
This is the first time the licensee has failed 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.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.