Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 10, 2024

Inspection Number: 2024-1328-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Lakefield, Lakefield

Lead Inspector	**Inspector Digital Signature**
Karyn Wood (601)	Karyn L Wood Digitally signed by Karyn L Wood Date: 2024.07.12 14:23:42 -04'00'

Additional Inspector(s)
Chantal Lafreniere (194)
Yvonne Gaudaur (000804)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-7, 13, 14, 17-21, 2024.

The following intake(s) were inspected:

- A complaint regarding falls management and neglect of a resident.
- Follow-up #1 - O. Reg. 246/22, s. 102 (2) (b) regarding Infection Prevention and Control (IPAC).
- A complaint regarding staffing levels, neglect, isolation policies, lack of activities, missed bathing and meals.

- A complaint regarding a missing resident, staffing levels, and neglect.
- A CI regarding a missing resident.
- A complaint regarding elopement of a resident.
- A CI regarding a missing resident with injury.
- Four CIs were completed in this inspection related to a fall with injury.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1328-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Yvonne Gaudaur (000804)

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

Resident Care and Support Services
Continence Care
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

A complaint was submitted to the Director that a resident's care needs were not being met including the management of the resident's responsive behaviour.

The resident's plan of care for responsive behaviour included safety interventions if the resident was near a specified location. Observation of the video surveillance and interview with an agency worker identified the planned safety interventions were not implemented. The resident entered a specified location that placed them at risk for injury due to a responsive behaviour.

Sources: Email sent to agency, plan of care, progress notes, video surveillance, and interviews with the one-to-one agency worker. [601]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in the plan of care for two residents were documented.

Rationale and Summary

A Critical Incident (CI) and a complaint were submitted to the Director that the residents had a responsive behaviour that placed them at risk for injury.

The residents plan of care included hourly safety checks to manage their risk for injury.

The Personal Support Workers (PSW) were required to document the residents' safety checks and provisions of care using Point of Care (POC).

1) Resident #001's documentation for safety checks, food and fluid intake, and bathing was incomplete.

2) Resident #004's documentation for safety checks was incomplete.

PSWs and registered staff reported that time constraints due to staffing shortages would often delay documentation and there were times when the documentation in POC wouldn't reflect the actual care that was provided.

The Director of Care (DOC) confirmed they were aware of PSWs reporting insufficient time to complete their documentation in POC due to staffing deficiencies. The DOC reported the PSWs had received education regarding the importance of completing documentation. The DOC confirmed there were shifts when PSWs were working below complement and the resident's personal care documentation was incomplete.

Failure to ensure the provision of care set out in the resident's plan of care was documented placed the resident's well-being at risk due to a decreased ability to effectively monitor and evaluate their interventions.

Sources: Residents Documentation Survey Report, Care Plan, Progress Notes, Daily Roster Reports, and interviews with staff. [601]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that two residents were bathed, at a minimum, twice a week.

Rationale and Summary

A complaint was submitted to the Director that resident care needs were not being met including missed bathing due to staffing shortages.

There were several days when the residents' bathing documentation on their scheduled bath days were incomplete. Staff confirmed there were days when the residents did not receive their scheduled bathing due to staffing shortages.

The Nursing Staffing Clerk (NSC) and the DOC confirmed there were several evening shifts when the resident's home area did not have the full staffing complement of PSWs. The DOC acknowledged there were times when the residents did not receive their scheduled bath due to staffing shortages.

Failure to ensure the resident received their scheduled baths twice a week could affect the resident's quality of life and place them at risk for poor personal hygiene, and other care concerns.

Sources: Residents' progress notes, documentation survey reports, care plan, and interviews with staff. [601] [000804]

WRITTEN NOTIFICATION: Social work and social services work

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 68

Social work and social services work
s. 68. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

The licensee has failed to ensure that there was a Social Worker available for a resident.

Rationale and Summary

The resident had a cognitive impairment with responsive behaviours.

The Social Worker was identified as part of the interdisciplinary leadership team. The written description of the Registered Social Worker's roles and responsibilities included mental health and responsive behaviours. The Administrator acknowledged the resident's Substitute Decision Maker (SDM) had requested the resident receive the services of a Social Worker. The Administrator confirmed there was no Social Worker currently working in the home and was not available for the resident upon the request of the resident's SDM.

Failure to provide a social worker to support the resident's responsive behaviours had a negative impact on the resident.

Sources: A resident's clinical health record, Extendicare Registered Social Worker Roles and Responsibilities, and interviews with the Administrator. [601]

WRITTEN NOTIFICATION: MENU PLANNING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

Rationale and Summary

Inspector #194 observed that the morning nourishment/snack was not provided to the residents on several home areas.

The snack menu directed that fluids were to be provided to the residents between breakfast and lunch. Interviews with several staff confirmed that the morning nourishment was not always provided to the residents related to staffing shortages and time constraints.

The residents were at risk for dehydration when the morning nourishment pass was not offered or provided.

Sources: The snack menu, observation of the nourishment pass, and interview with staff. [194]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary

A complaint was submitted to the Director that the resident's care needs were not being met including monitoring the resident to prevent an injury.

The resident was transferred and admitted to the hospital following an unwitnessed fall that resulted in an injury.

The DOC acknowledged a CI regarding the incident or a call to the Ministry's after-hours line was not made to inform the Director of the resident's injury or the outcome of the internal investigation.

By not ensuring the Director was immediately informed when the resident fell and was transferred to the hospital with a significant injury placed the resident at risk due to a lack of transparency and communication with the Director.

Sources: A resident's progress notes, post fall assessment, Hospitalist Discharge Summary, and interview with the DOC. [601]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to ensure that the CI was updated with the outcome and status of the individual involved in the incident.

Rationale and Summary

A CI was submitted to the Director reporting a resident's fall. The CI was not updated to report the extent of the resident's injury and the negative outcome to the resident. The Registered Nurse (RN) documented in resident's progress notes that the

resident had been diagnosed with a with a significant injury.

The Administrator confirmed that the CI should have been amended to indicate that the resident had sustained a significant injury and negative outcome.

Failure to update the CI with the resident's outcome and status, did not allow for proper follow up.

Sources: A CI, a resident's clinical health records and interview with the Administrator. [000804]

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A complaint was submitted to the Director that a resident's care needs were not being met including concerns with the resident's medication administration.

The resident's morning medication prescribed by the physician's was not available from the pharmacy to administer the day after the resident returned from the hospital. An RPN acknowledged the resident had not received their medication due to the medication not being available from the pharmacy.
The resident was at risk for a decline in their health condition when there was an omission in administering the resident's medication to manage their health condition, as prescribed by the physician.

Sources: A resident's progress notes, electronic Medication Administration Record, and interview with staff. [601]

WRITTEN NOTIFICATION: CMOH and MOH

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued, such as having Alcohol Based Hand Rub that is not expired, by the Chief Medical Officer of health, are followed at the home.

Rationale and Summary

During a tour of the home, a resident lounge and a table outside of a resident's room

was noted to have expired Alcohol Based Hand Rub (ABHR).

Infection Prevention and Control (IPAC) lead confirmed that the ABHR were to be checked and refilled by the Environmental Services Manager (ESM). The ESM indicated that their team were responsible for checking and ensuring that the ABHR was not expired in the home.

Failing to ensure that the ABHR was not expired, increased the risk for spread of infection at the home.

Sources: Tour of the home and interview with staff. (IPAC lead and ESM) [194]

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

1) The Administrator will designate a person responsible to oversee the wander guard system, including the pocket tag reader and resident wander guard tags to

ensure the equipment is functioning properly.

2) The Administrator or DOC will ensure that a specified resident's wander guard tag is replaced immediately when the pocket tag reader or staff identify the resident's tag is not functioning properly. Ensure a documented record is kept with the reason identified for the resident's wander guard tag not functioning properly and the steps that were taken to ensure the resident's safety. Provide the records to the Inspector immediately upon request.

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

Rationale and Summary

A complaint and CIs were submitted to the Director regarding the wander guard system.

Two residents had a safety device in place for a responsive behaviour and there were occasions when the safety device did not function properly.

Two residents had been assigned the same safety device and the safety of both residents was placed at risk when the safety device did not function properly. The safety device was scheduled to be checked by registered staff daily using the pocket tag reader. The DOC and the Administrator acknowledged that a resident's safety device was not functioning properly on one occasion, and the resident was provided with a new safety device when the issue was identified.

The following non-compliances were identified within this report specific to the

safety of the residents and the wander guard system:

-FLTCA, 2021, s. 6. (7) - The licensee has failed to comply with a resident's plan regarding their responsive behaviour.

-O. Reg. 246/22, s. 26 - The licensee has failed to comply with the manufacturers' instructions on how to test the residents safety devices using the pocket tag reader.

-FLTCA, 2021, s. 6 (9)1 – The licensee has failed to ensure the safety monitoring documentation for two residents set out in the plan of care was completed.

The interventions to manage the residents safety was not effective and placed the resident's at risk for injury.

Sources: Residents progress notes, electronic Medication Administration Record, the licensee's internal investigation and witness statements, Observation of Video Surveillance, two CIs, and interviews with staff. [601]

This order must be complied with by August 16, 2024

COMPLIANCE ORDER CO #002 Compliance with manufacturers' instructions

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in

accordance with manufacturers' instructions.

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

1) The Administrator or DOC will provide education to all registered nursing staff providing tag checks according to the manufacture instructions. The education should include direction on how to operate the reader according to manufacturer instructions, when the resident tags should be tested, how to identify if the pocket tag reader and resident tags are functioning properly, to replace the resident's tag when not functioning properly, and where to document the outcome of the resident tag checks.

2) Ensure a documented record is kept pertaining to part one of this order including the content of education provided to the registered staff related to wander guard system, including the individual who provided the education, names of registered staff attending the education and the date the education was provided. Provide the records to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that staff use all equipment, and devices in the home in accordance with manufacturers' instructions.

Rationale and Summary

A complaint and CIs were submitted to the Director regarding the safety of the wander guard system.

Registered staff interviews, witness statements, and observations by Inspector #601 identified staff were not following the manufacturer instructions for the pocket tag reader.

Failure to follow the manufacture instructions to test the resident's safety device using the pocket tag reader increased the residents' risk for injury.

Sources: Manufacturer instructions and user guides, the licensee's internal investigation and witness statements, observations, and interviews with staff. [601]

This order must be complied with by September 10, 2024

COMPLIANCE ORDER CO #003 Nursing and personal support services

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

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

1) The DOC will develop a written process that includes the following:

a) Assign an RN, who regularly works in the home or a manager on every shift that will be responsible for determining that residents' safety and care needs are met when there are staffing shortages.

b) Provide direction to the assigned RN or Manager to obtain a verbal report from nursing staff on each unit regarding workload issues at the beginning and middle of each shift when there are staffing shortages.

c) Provide direction to determine when staff need to be reassigned to a different unit throughout the shift, to meet the residents' assessed care needs. Staff are to collaborate and work together until all residents receive personal care, in a timely manner.

d) Document a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident care needs have not been met.

2) Provide the written process and the documentation of the contingency plans to Inspectors immediately upon request.

3) Review and update the home's current back up staffing plan to reflect:

-The janitor position is no longer available.
-On-call manager to be notified with staff shortages of more than two staff during any shift.
-Directions for on-call manager to document on how the back up plan was implemented and any actions taken.

4) Each department, Dietary, Programs, Nursing and Management are to provide written evidence that the back up plan was in place and identify which staff were

involved for a period of four weeks. The documented evidence is to be kept and made available to inspector immediately upon request.

5) Weekly audits for four weeks, of the staffing shortages at the home and how they were managed. The audits are to be completed by the DOC, and they are to include the number of RN, RPN and PSW vacancies for each shift. Audits should also include what actions were taken including if agency staff was called, were all staff offered the shift, if all departments were reassigned, who was the on-call manager, and when they were notified.

Grounds
The licensee has failed to ensure the staffing mix was consistent with the resident's assessed care and safety needs when the resident did not receive care according to their assessed needs.

Rationale and Summary

There were complaints that staffing shortages resulted in residents not receiving their scheduled baths.

Non-compliance was identified within this report regarding staffing shortages with:

- O. Reg. 246/22, s. 37 (1) regarding residents did not receive a minimum of two baths per week, by method of their choice.

- FLTCA, 2021, s. 6 (9)1 regarding the documentation for residents provision of care were incomplete.

- O. Reg. 246/22, s. 77 (5) regarding planned menu items not offered at each snack.

The DOC acknowledged the staffing schedule changed daily and there were shifts when the staffing levels were below the staffing complement. The DOC indicated attempts for staff recruitment was ongoing and there were PSW and Registered staff positions not filled according to the staffing plan. According to the DOC, several agency staff have been working in the home and efforts have been made to provide continuity of resident care.

The back up staffing plan outlined strategies that were to be implemented by the home when the staffing compliment could not be achieved. The licensee has failed to implement its back up plan. The licensee has not been able to recruit and retain staff according to the licensee's staffing plan.

There was risk for harm when the residents' assessed care needs were not met due to staffing shortages.

Sources: Master Schedule, Daily Staffing Cheat Sheets, Staffing plan, back up staffing plan, Evaluation of Staffing Plan, and interviews with staff. [194]

This order must be complied with by September 10, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

1) Provide leadership, monitoring, and supervision from the management team or a designated registered staff in all home areas for a period of two weeks by being present on each home area for a period of at least 20 minutes on each shift to ensure staff adherence with appropriate IPAC practices while staff are providing resident care. Keep a documented record of who was assigned to be out on the units, including dates and time periods and make immediately available for Inspectors, upon request.

If the designated registered staff is assigned the task, they should not be scheduled to provide direct nursing care on the home area while they are ensuring adherence with IPAC practices.

2) Within two weeks of receipt of this CO the IPAC lead or qualified nursing management designate will conduct daily audits for one week and then twice weekly audits for the period of two weeks of PPE donning. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) The DOC and IPAC lead will develop and implement a process for residents who are non-compliant with isolation precautions, including resident specific interventions to minimize the risk. Ensure all staff, including agency staff are informed of the resident specific interventions, additional precautions in place and what PPE is required.

Grounds

1. The licensee has failed to ensure that Additional Precautions were followed in the IPAC program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Requirement 9.1 under the IPAC Standard, directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

At minimum, section 9.1 (f) for Additional Precautions shall include additional PPE requirements including appropriate selection, application, removal, and disposal.

Rationale and Summary

An Agency Resident Care Aide (RCA) was observed assisting a resident with a responsive behaviour outside of their room. The RCA walked the resident to their room and then entered the resident's room, with signage posted for droplet and contact precautions. RCA was not wearing any PPE during the observation. The RCA confirmed that they were not informed that the resident had been placed in isolation for droplet contact precautions. The RCA confirmed that they knew what the additional precaution signage meant but did not see the signage before entering the resident's room.

Failing to don appropriate PPE when caring for resident under additional precautions, put residents at risk for spread of infection.

Sources: Observation of resident and staff interactions, review of a resident's progress notes and interview with an Agency RCA. [194]

2. The licensee has failed to ensure that Additional Precautions were followed in the IPAC program in accordance with the IPAC Standard for LTCH, revised September 2023.

Additional Requirement 9.1 under the IPAC Standard, directs the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program.

At minimum, section 9.1 (f) for Additional Precautions shall include additional PPE requirements including appropriate selection, application, removal, and disposal.

Rationale and Summary

A resident was on droplet and contact precautions and an RPN was observed wearing gloves while providing resident care within six feet. The RPN was not wearing a gown, face mask, and eye protection. The RPN acknowledged the resident required additional precautions and they should have donned a gown, face mask, and eye protection prior to entering the resident's room.

Residents were placed at risk for spread for infection when the RPN failed to wear the proper PPE while caring for the resident under additional precautions.

Sources: Observation of a resident and an RPN, and an interview with the RPN. [601]

This order must be complied with by August 16, 2024

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 #004

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:

Prior non-compliance with O. Reg. 246/22, s. 102 (2) (b), resulting in:

Written Notification (WN) issued on May 10, 2023, in #2023-1328-0001
Compliance Order (CO) issued on March 7, 2024, in #2024-1328-0001

This is the first AMP that has been issued to the licensee for failing to comply with

this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.