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
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Original Public Report

Report Issue Date: November 26, 2024

Inspection Number: 2024-1328-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Lakefield, Lakefield

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7 -11, 15 -18, 21, 2024

The following intake(s) were inspected:
An intake related to a first follow up to CO(HP) #001, from Inspection #2024_1328_0002 related to O. Reg. 246/22, s. 5 with a CDD of August 16, 2024.
An intake related to first follow up to CO #002, from Inspection #2024_1328_0002 related to O. Reg. 246/22, s. 26 with a CDD of September 10, 2024
An intake related to first follow up to CO #003 from Inspection #2024_1328_0002 related to O. Reg. 246/22, s. 35 (3)(a) with a CDD of September 10, 2024.
An intake related to first follow up to CO #004, non-compliance with O. Reg. 246/22, s. 102 (2)(b) with a CDD of August 16, 2024.
An intake related to a fall incident
An intake related to concerns re: RSA working as PSW and providing personal care.
Four intakes related to fall incidents

An intake related to allegations of neglect
An intake related to concerns of neglect of resident and safety
An intake related to concerns re falls and skin and wound
An intake related to outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1328-0002 related to O. Reg. 246/22, s. 26 inspected by the Inspector.
Order #004 from Inspection #2024-1328-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by the Inspector

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1328-0002 related to FLTCA, 2021, s. 5 inspected by the Inspector
Order #003 from Inspection #2024-1328-0002 related to O. Reg. 246/22, s. 35 (3) (a) inspected by the Inspector..

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

Continence Care
Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1.The licensee failed to immediately report allegations of neglect of a resident to the Director.

Rationale and Summary

A Critical incident report (CIR) was submitted to the Director for allegations of neglect of a resident.

Staff reported the allegations to a Registered Nurse (RN) immediately. The RN indicated they completed the home's incident report and contacted the Substitute Decision Maker (SDM) for the resident but acknowledged they did not report the allegations of neglect to the Director stating this was due to time constraints.

The Director of Care (DOC) and Acting Administrator (AA) indicated that it is the expectation of the staff to immediately report allegations of neglect to the Director and acknowledged that this was not done.

Failing to report allegations of neglect of a resident to the Director posed a risk that the allegations were not immediately addressed by management of the home to improve staffing.

Sources: CIR, resident's clinical health records, interviews with staff.

2.The licensee failed to report to the director an incident of sexual abuse between residents.

Rationale and Summary
During a follow up compliance inspection, clinical health records documented that staff found two residents exhibiting nonconsensual responsive sexual behaviours. The Personal Support Worker (PSW) indicated the expectation of the home is to report nonconsensual sexual responsive behaviours immediately and acknowledged that they reported the incident immediately to their Registered Practical Nurse (RPN).

The RPN stated they were not sure of the home's definition of sexual abuse but said and acknowledged they did not know to report it. The RPN agreed sexual abuse would be nonconsensual activity of a sexual nature and acknowledged that both residents would not be able to consent.

The BSO Lead, and the DOC acknowledged the home has a zero-tolerance abuse and neglect policy and that nonconsensual sexual behaviours between residents are to be reported immediately. The Acting Administrator indicated that it is the expectation of the home to follow the Zero Tolerance abuse and neglect policy and that allegations of abuse are to be reported immediately.

Failing to report sexual abuse allegations between residents to the Director resulted in risk when the staff did not understand the definition of sexual abuse and communicate the interaction to other staff of the home.

Sources: Resident's clinical health records, Policy Zero Tolerance of Resident abuse and neglect: Response and Reporting.

WRITTEN NOTIFICATION: Conditions of License

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

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of license

s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

The licensee has failed to comply with the Compliance Order (CO) (HP), #001 from Inspection #2024_1328_0002, with a compliance due date (CDD) of August 16, 2024.

Rationale and Summary

The home was ordered to 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 and did so in designating the Maintenance Aide for the home.

The Administrator or DOC was also ordered to ensure that a resident 's wander guard tag is replaced immediately when the pocket tag reader or staff identify the residents tag is not functioning properly, and to ensure a documented record was kept with the reason identified for the residents wander guard tag not functioning properly and the steps that were taken to ensure the residents safety.

Compliance documents provided by the home showed that on a specified date, and time ,a resident eloped from the home. The Report for Roam Alert tag malfunction indicates the tag was replaced and tested to ensure proper operation the next day. A review of the clinical records for a resident details that on a specified date, the wander guard roam alarm went off and staff observed a resident eloping from the

home.

Records show that on a specified date the following week, a resident was found between the two front doors and staff were unable to redirect them and resident was almost onto the driveway before staff could redirect them back to the home. Elopement records indicate that resident was able to leave with the bypass code being used, and there is no documentation that the resident's wander guard tag was checked to ensure it was working, nor was it replaced immediately.

A Registered Nurse (RN) indicated that the expectation of the home is to replace wander guard tags immediately if they malfunction. The RN acknowledged on a specified date a resident's elopement was reported to them but felt that the Registered Practical Nurse (RPN) had the roam alert pocket reader on their medication cart and would have checked and replaced the resident's wander guard tag. The RN acknowledged they completed the incident report for the resident's elopement and did not immediately replace resident's wander guard tag or report the elopement to Management.

The Director of Care (DOC) confirmed that a resident's wander guard was not immediately replaced when it was not working, and they eloped from the home.

Failure to comply with CO #001 posed a risk to a resident who was at risk of eloping from the home.

Sources: CO #001 from inspection #2024_1328_0002, Home's compliance documents, resident's clinical health records, interviews with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

WRITTEN NOTIFICATION: Conditions of license

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

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of license

s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

The licensee has failed to comply with CO #003 from inspection #2024-1328-0002 served on July 10, 2024, with a compliance due date of June 30, 2024.

Specifically, there was no documentation of a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident

care needs were not met and there was not sufficient staffing as per the homes Staffing Contingency Plan.

Rationale and Summary
An interview with the Director of Care (DOC) acknowledged that a brief description of the staffing contingency plan when there were staffing shortages had not been implemented and there was not sufficient staffing as per the homes' Contingency Plan. An interview with the Vice President of Extendicare, Regional Director, and Interim Administrator were not aware of Compliance Order #003 and were unaware of the requirements and documentation of Compliance Order #003 presented to the Inspector.

Sources: : CO #003 from #2024_1328_0002, review of audit records, interviews with staff.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002
NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)
The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #003
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.
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WRITTEN NOTIFICATION: Plan of Care
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee failed to base the plan of care for a resident on identified responsive behaviours.

Rationale and Summary
During a review of the clinical health records for a resident for a follow up compliance inspection, the progress notes indicated that Registered Practical Nurse (RPN) documented an incident of resident-to-resident responsive behaviors.

The home's responsive behaviour policy directs that the plan of care includes any identified behaviours, a description of the behavior, triggers, preventative measures, and resident specific interventions to address behaviours.

Progress notes for two residents document multiple incidents of responsive behaviours requiring monitoring and redirecting by nursing staff. The plans of care

for these specified residents did not include any information related to these identified behaviours. Following the responsive behaviour incident, the plan of care was not updated to include escalated responsive behaviours.

The BSO Lead indicated that a resident has a history of responsive behaviours and acknowledged they were not indicated in the plan of care. DOC indicated that the residents plan of care should have provided a focus for responsive behaviours and interventions to promote safety

Failing to ensure the plan of care for the residents included their responsive behaviours, and not directing staff how to evaluate the residents to determine consent posed a risk to the residents.

Sources: Clinical health records for residents, Policy Responsive Behaviours, interviews with staff.

WRITTEN NOTIFICATION: Qualifications of personal support workers

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

Non-compliance with: O. Reg. 246/22, s. 52 (1) (a)

Qualifications of personal support workers

s. 52 (1) Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,

(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and

Every licensee of a long-term care home shall ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,

(a) has successfully completed a personal support worker program that meets the requirements in subsection (2).

Rationale and Summary:
A complaint was submitted to the Director with an allegation that a Resident Support Aide (RSA) was observed on a specified date, working in the role of a Personal Support Worker (PSW).

A record review of the RSA employee file indicated that the RSA did not possess a PSW certificate, and was in a former part time Janitor role in the home, before assuming the duties of a RSA.

An interview with the DOC indicated that a PSW certificate is required to fulfill the role of a PSW in the home. The DOC indicated that they were unaware that any RSA was working in the role of a PSW. The DOC confirmed that they have approved the RSA to stay beyond their end of shift to work overtime to assist the PSW's who are working short, but the RSA is not to do any personal care. Interviews with a PSW who was new to the home, confirmed that the RSA helped them complete personal care on a resident on several occasions. The PSW confirmed that they have witnessed the RSA doing personal care on residents and reported this verbally and in writing to the Former Administrator and DOC. An interview with the RSA denied working as a PSW.

The home had permitted the RSA to provide care in the full scope of a PSW, which placed all residents at a safety risk.

Sources: Written documentation kept by the complainant, Job Descriptions, Interviews with staff.

WRITTEN NOTIFICATION: Continence care and bowel management
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee failed to ensure that a resident had a continence assessment conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of continence.

Rationale and Summary
The Continence management policy of the home directs staff to complete a continence assessment using the clinically appropriate tool in Point Click Care on admission and for significant changes.

The Clinical Coordinator reviewed the clinical health records for a resident during an interview and acknowledged that the continence assessment for the resident was not completed on admission.

Failing to complete a continence assessment for resident posed a risk that their plan of care would not be implemented to meet their individual needs.

Sources: Continence Management Policy, clinical health records of resident and interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident who required continence care received sufficient changes to remain clean, dry and comfortable.

Rationale and Summary
A Critical Incident report (CIR) was submitted to the Director related to allegations of neglect for continence care not being completed for a resident. A complaint was also submitted to the Director regarding the resident's care needs not being met due to staff deficiencies and continence care not being provided in a timely manner.

The plan of care for the resident directs staff that resident is to be checked or changed every 2-3 hours for wetness, The home's internal investigation notes for the complaint, indicate that POC documentation showed care was given to the resident on a specified date, at 0830, 1230, 1300, 1430 and no documentation was available for evening shift.

The Follow up question report for continence-prompted voiding for a specified date, indicates that the resident did not void or was continent on the night shift, and that they were incontinent at 0830 and 1230. The report further indicated they were documented as being continent for their scheduled task at 1430. There was no documentation for continence-prompted voiding for the resident for every evening from a specified date.

Progress notes on a specified date indicate that there was a profuse smell and the PSW reported the resident's bed was saturated also indicating the unit had been short staffed.

A PSW indicated that they found a resident soaked and that they reported that it did not look like care at been done on days and they acknowledged they thought it was

as a result of insufficient staff to change them on days.

The RAI Coordinator indicated there were significant gaps in the documentation for the care for the resident and acknowledged if the care is not documented it is considered not done.

Failing to ensure a resident had sufficient changes to remain clean, dry and comfortable posed a risk of discomfort and worsening skin conditions.

Sources: CIR, Complaint, clinical health records of resident, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours.

Rationale and Summary
The Responsive Behaviour policy of the home indicates that each resident will be assessed and observed for responsive behaviours on admission, quarterly and as needed, and the home will implement and evaluate strategies and interventions to prevent, minimize and address responsive behaviours.

The clinical health record for a resident indicated a Behaviour Support Ontario (BSO) referral was completed on a specified date, for a resident exhibiting responsive

behaviours

Since admission to the home the resident had displayed multiple occurrences of responsive behaviours.

A review of the plan of care for the resident revealed the responsive behaviour was not identified and there were no strategies developed or implemented to respond to these behaviours.

Progress notes for the resident indicate an incident of responsive behaviour towards a resident on a specified date, and that there was no assessment, observation or BSO referral completed in response to their escalating occurrence of responsive behaviour.

The BSO Lead indicated they did not complete the BSO Referral initiated for the resident and that the plan of care did not include any interventions for identified responsive behaviours.

The DOC indicated it was the expectation of the home that the plan of care would provide a focus for responsive behaviours and acknowledged it did not provide any interventions to promote resident safety.

Failing to develop and implement strategies to respond to the responsive behaviours of a resident posed a safety risk to themselves and other residents of the home.

Sources: Resident clinical health records, Responsive Behaviour policy, and interviews with staff.

WRITTEN NOTIFICATION: Food Production

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

Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness.

Rationale and Summary:
During a tour of the home, the following was observed:
On a specified date, two nourishment carts on two home areas there were no lids on the water, apple, cranberry. and orange juices.
On a specified date, two nourishment carts on a specified home area there were no lids on the water, apple, cranberry. and orange juices.

During an interview with the Food Service Manager (FSM), they confirmed that they have some extra lids in the home and would order more. They also confirmed that on nourishment carts in the home, the juice and water containers are to have lids and are to be kept covered in order to prevent adulteration, and food borne illness.

Failure to keep fluids in a container with a lid placed the residents at risk of adulteration, contamination and food borne illness.

Sources: Observations, interview with FSM.

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) (i)

Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) 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;

The licensee shall ensure that procedures are developed and implemented to ensure that,(i) 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:
During a tour of the home, the tub and shower rooms were observed.

The homes policy Bathing Showering and Water Temperature Monitoring indicate that the care staff are to do water temperature checks to ensure the water temperature is between 40-49 degrees Celsius. If the water temperature is below 40 degrees Celsius, the following should take place:
i. warm up the water unless the resident specifically requests otherwise
ii. Notify the supervisor or maintenance if the situation cannot be resolved
iii. Find and alternative bathing/showering option and document this.

A record review of the tub temperatures indicated that for a specified month.
-A specified unit temp taken on 15 occasions, day shift only temperatures recorded between 37.0-37.9 degrees Celsius
-A specified unit temp taken on 25 occasions, day and evening shift temperatures recorded between 37.0-38.0 degrees Celsius
-Shower temperatures are not recorded.

An interview with the ESM and DOC confirmed that the expectation of staff are to check water temperature prior to bathing and showering a resident, and this is not being completed before bathing on each shift and ensure that water temperatures

are not too cold.

Failure to ensure that temperatures are taken in the bathtub and shower and ensuring they are within range placed the residents at risk of being uncomfortable.

Sources: Bathing, Showering and Water Temperature Monitoring Policy, Tub Temperature logs, Interview with staff.

WRITTEN NOTIFICATION: Safe Storage of drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that two resident's medications were stored in an area that was secured and locked.

Rationale and Summary

During separate observations of two resident's rooms medication containers labelled as prescription medication, with each resident's names were observed on their bedside tables.

The home's medication policy directs that all medications are to be stored in a secured, locked location accessible only to designated staff members.

Staff acknowledged that it is the expectation of the home that all medications are kept locked and secured in the medication room or cart.

Failing to ensure that residents medications were stored in a secure area posed a

risk to residents that they could consume or use medications unsafely.

Sources: Observations, Policy Medication Storage, Interviews with staff.

WRITTEN NOTIFICATION: Construction, renovation, etc.., of homes
NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (2)
Construction, renovation, etc., of homes
s. 356 (2) A licensee shall not allow alterations, additions, renovations, maintenance or repairs to be made to the home or its equipment that do not maintain or improve upon the functional aspects of the home or equipment.

A licensee has failed to ensure that alterations, additions, renovations, maintenance or repairs to be made to the home or its equipment maintained or improved upon the functional aspects of the home or equipment.

Rationale and Summary:
During a tour of the home, on two specified dates, shower rooms were altered and used as storage space for medical supplies and equipment.

An interview with staff confirmed that shower rooms are not to be used as storage for any equipment.

Failure to keep a shower room free of equipment placed the resident at risk of injury.

Sources: Observations, Interviews with staff.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment
NC #013 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)]:
The Licensee will:
1. The Administrator or designate will implement a process in the home that includes:
a.) That all elopements of residents are to be reported immediately to the Charge Nurse and Director of Care (or the Manager on call after hours
b.) That the wander guard tag is to be checked and replaced immediately, if found not working, for all attempted and actual elopements of residents.
c.) Identified safety interventions available to be implemented
2. The process is to be posted in an area visible to staff and communicated to nursing staff of all disciplines at change of shift for a period of three days. Attendance record to be kept of the dates and time of report meetings, who communicated the process, the names of staff, and signatures, who attended and make attendance records available to Inspectors immediately on their request.
3. Keep a record of the implementation of roam alert and door security improvements.
4. The home will complete a written audit for a four-week period of all attempted and actual elopements. The audit will include:
a.) Name of resident who attempted or eloped
b.) Date and time of elopement
c.) Reason resident was able to elope, if known
d.) Date and time wander guard tag was checked and results.
e.) Date and time wander guard was replaced if not working.
f.) Name of Manager and date and time they were notified.
g.) Safety interventions implemented.
h.) Follow up actions from management when the process is not followed.

i.) Who completed the audit for each attempted/actual elopement.
5. Keep a written record of the audit and make available to the Inspectors immediately upon their request.

Grounds
The licensee failed to ensure the home is a safe and secure environment for residents of the home.

Rationale and Summary
A complaint was submitted to the Director related to ongoing elopements of residents from the home.

The home's risk management incident reports were reviewed for elopements and on three separate occasions, three residents were found outside. Incident reports for four additional residents, each had two incidents of eloping from the home and being found outside.

A work order documented that the Contractor had met with the Director of Care to discuss improvements to the Roam alert system. They verified that the Roam alert system did not ring to pagers or corridor displays and investigated to find out that someone had removed the wiring to the nurse call controller and the system could only be heard locally at the front doors of the home .The system was rewired so that it connected to the staff pager systems so staff are alerted when someone leaves the building when they are out of range to hear it at the front door.

A document entitled Roam Alert Improvements detailed the home's plans for improvements and interventions in place to limit risk of elopement. The home removed chairs away from the lobby area to deter residents lingering by the front doors as well as implemented agency staff to remain at the front door for twelve house each day for safety reasons.

Additionally, an exterior alarm panel was installed to the outer doors, and the Fire department attended on a specified date and provided written documentation that they had no concerns with its use for safety and security of the home.

Interviews with the Maintenance Aide, Director of Care and Acting Administrator indicated they were aware of ongoing elopements and acknowledged that roam alert improvements had been identified and were in the process of being implemented but were not completed. The contractor for the roam alerts was present on the last day of the inspection continuing to work on the roam alert to ensure it was functioning correctly.

Failing to ensure the roam alert system and wander guard tags are functioning posed a risk that residents may elope and become missing or injured.

Sources: Clinical records for residents, work orders, roam alert documentation, interviews with staff.

This order must be complied with by January 31, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003

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 $1100.00, to be paid within 30 days from the date of the invoice.

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

the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

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.

COMPLIANCE ORDER CO #002 Documentation

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The Licensee will:

1. The Director of Care will implement a process to follow up with staff who do not complete documentation of care and safety tasks..
2. The Director of Care or designate will audit documentation once a week for Kawartha home area for a four-week period. The audit will include:

a.) Resident names that had missing care and safety tasks for the week

b.) Follow up given with nursing staff who missed documentation, including the name of staff, date of follow up, reason staff missed the documentation and the interventions in place to improve documentation.

Keep a documented record of the process and audit and make available to the inspectors immediately upon their request

Grounds
1.The license failed to ensure that the provision of the care set out in the plan of care for a resident was documented:

Rationale and Summary
A complaint was submitted to the Director related to a resident not receiving care due to short staffing.

A review of a resident's clinical health records indicates that documentation for care on evenings was missing on specified dates and many of the tasks assigned including continence care, safety checks, bathing and behaviours were not documented as provided.

Staff indicated that the home was short staffed the majority of the time during those dates and they had insufficient time to complete documentation.

Staff indicated the home was aware of significant gaps in documentation for a resident they were auditing and providing education to nursing staff to improve documentation and acknowledged that staff were completing less documentation when short staffed.

Failing to ensure care for a resident was documented as provided causes an uncertainty if care is provided for or not when short staffed poses risk to resident quality of life.

Sources : Complaint, clinical health records for a resident, interviews with staff.

2.The license failed to ensure that the provision of the care set out in the plan of

care for a resident was documented:

Rationale and Summary
A critical incident report (CIR) and complaint was submitted Director related to allegations of abuse and neglect for a resident.

A review of a resident's clinical health records indicated that documentation for their care tasks was incomplete in specific months of documentation for care tasks.

Staff indicated it is the expectation of the home that documentation of care is completed and acknowledged the home was aware of significant gaps in documentation.

The Director of Care (DOC) acknowledged that incomplete documentation does not provide evidence that a resident received care according to their plan of care.

Failing to ensure care for a resident was documented poses a risk to quality of life when care was not completed according to the plan of care.

Sources: CIR, complaint, residents point of care documentation, interviews with staff.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #003 Nursing and personal support services
NC #015 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)]:

The Licensee will:

1.The Administrator and Director of Care will communicate the home's staffing contingency plan to Registered Nursing staff of the home including a list of agency contacts the registered staff can contact after hours when below staff complement.

2.Make the home's staffing continency plan available to those who are responsible for filling staffing vacancies including after hours and on weekends.

3. Implement a written process to recruit and hiring staff to fill nursing vacancies in the home.

4. Complete an audit once a week for a four-week period. Include in the audit:

a.) The number of nursing positions vacant, including those unfilled by absence

b.) The number of nursing staff interviewed

c.) The number of nursing staff hired.

5 Keep a written copy of the staffing contingency plan, process for recruitment and hiring and audit, and provide to Inspectors immediately upon their request..

Grounds

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

Rationale and Summary

A critical incident report (CIR) and complaint were submitted to the Director related to allegations of neglect of a resident related to care not being provided. The allegations included complaints that the staffing complement was insufficient to meet the assessed needs for the resident.

Staff indicated they were aware that the home had insufficient staffing on a specified date and this contributed to a resident missing care,

A review of staffing attendance records indicated that the home was below complement of staffing mix on a resident's unit indicating on days and evenings they had two PSW staff for 25 residents instead of three. Recruitment documents provided from the home revealed the home had multiple staff vacancies.

Non=compliance was identified within this report regarding staff shortages:

-FLTCA 2021, s. 6 (9) regarding documentation of the provision of care provided for a resident
-O. Reg 246/22 s. 37 regarding a resident not receiving a minimum of two baths per week.
-O. Reg 246/22 s. 56 (2) (g) regarding a resident receiving sufficient continence care changes to remain clean, comfortable, and dry

The Director of Care and Acting Administrator acknowledged the home has had staffing challenges and there were shifts when the staffing levels were below the complement. The licensee has not been able to recruit and retain staff according to the licensee's staffing plan. The Acting Administrator indicated the home had multiple nursing vacancies and acknowledged that the home is now receiving corporate support to recruit and hire staff.

Failing to ensure the staffing mix is consistent to meet the assessed needs for a resident resulted in their not receiving continence care and baths posing a risk to their comfort and quality of life.

Sources: CIR, complaint, Clinical health records for a resident, staffing attendance records, recruitment documents, interviews with staff,

2.The licensee has failed to ensure that the staffing mix was consistent with the contingency plan.

Rationale and Summary:
A review of the staffing plan for the home indicated that three Personal Support Workers (PSW) are to be assigned on every home area on the day shift.

The homes' Staffing Contingency Plan revealed that when there are only 2 PSW's on a shift, Agency partners currently on contract with the home and who have been oriented with the home are contacted. The home utilizes the use of a specified agency for PSW assignments. The home provided a list of agencies with whom, the licensee has a contract and there are six Preferred Agencies and twenty- four other contracted agencies, both for clinical and nonclinical support.

A record review of the schedule revealed multiple dates where the staffing plan was not met.

Interviews conducted with the DOC and the On Call manager who was the ESM, confirmed that the home was not adequately staffed with PSW's as per the staffing plan, and the contingency plan to contract other agencies that were available was not done and should have been. The Acting Administrator and Regional Director who were both on site during the inspection were not aware of the staffing plan for the specified dates and did not inquire about the staffing schedule. Staff confirmed they are not aware of other agencies that were available, and had no other contact information for those agencies.

The licensee has failed to implement its' contingency plan, resulted in a risk of harm when the residents' assessed care needs according to the staffing plan and contingency plan were not met due to staffing shortages.

Sources: Schedule, Staffing Contingency Plan , Agency Tier 1 and Tier 2 List. interviews with staff.

This order must be complied with by January 31, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #004

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #004

Related to Compliance Order CO #003

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:

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.

COMPLIANCE ORDER CO #004 Bathing

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The Licensee will:

1.Implement a process to communicate when a specified resident does not receive their bath a minimum of two times per week that this is reported immediately to the Director of care and documented the report of this in the residents plan of care.

2.Implement a back up plan that can be implemented when short staffed to ensure that missed baths are completed and communicate this plan to nursing staff.

3.Complete a weekly audit for a four week period for Stoney home area. The audit is to include:

a.) Resident name and dates for the audit.

b.) If the resident received their minimum of two baths per week, or the baths outlined in their plan of care as their preference.

c.) if the resident did not receive their minimum of two baths per week what was the reason they did not.

d.) The person who completed the audit.

4.Keep a copy of the process of communication, back up plan and audit and make available to the Inspectors immediately upon the request

Grounds

1.The licensee failed to ensure a resident was bathed a minimum of twice weekly by a method of their choice.

Rationale and Summary

A complaint was submitted to the Director related to care not being provided to a resident due to short staffing.

The plan of care for the resident indicated that they were to have two baths per

week. The resident's Point of Care (POC) documentation indicates they had missed having their two scheduled baths in a ten-day timeframe.

Staff indicated that they had a lower-than-normal staff complement as there were only 2 staff instead of 3 and baths are not done, plan is to make up baths the next day unless they are short. Staff indicated that if they are short a PSW there is no time to document or do baths.

Staff indicated the priority is care and when short staffed, the baths can be moved to the next day. Staff reviewed resident's clinical file and that the resident did not receive their bath for eleven days, and acknowledged this is not providing care in accordance with their plan of care.

Failing to ensure a resident received a minimum of two baths a week posed a risk to their quality of life.

Sources: Complaint, clinical health records for resident and interviews with staff.

2.The licensee failed to ensure a resident received a minimum of two baths per week.

Rationale and Summary
A Critical Incident Report (CIR) and complaint were submitted to the Director related to allegations of abuse and neglect and care issues for a resident.

The resident's plan of care directed the resident preferred a tub bath on the day shift of two identified days a week. A review of the resident's clinical health records showed that documentation for baths was incomplete for seven dates in a specific month.

Staff indicated it is the expectation of the home that residents receive a minimum of

two baths per week and acknowledged that the home was short staffed and had insufficient time to complete baths. The DOC indicated the homes back up plan is if the home is short staffed they are to complete the bath on the next day and acknowledged the home was frequently short staffed and this is not always possible.

Failing to ensure a resident receives a bath a minimum twice per week poses a risk for increasing skin alteration and discomfort.

Sources: CIR, complaint, resident's clinical health records, interviews with staff.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #005 Transferring and positioning techniques
NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee will:
1. The Administrator or designate will educate all nursing staff including agency staff any any other staff assisting with resident transfers, that residents are not to be transported in wheelchairs without their footrests in accordance with their Resident Care equipment policy.
2. The home will keep a written record of the education including content, attendee names, dates of attendance, and who provided the education, and make this record immediately available to the Inspectors upon request.
3. The Administrator or designate will complete four audits, one audit for each of the

four home areas, not to be completed on the same day. The audit will include.
a. An observation completed when staff are transporting multiple residents, specifically before or after meals, or to/from large group activities.
b. Date and time of the audit, home area and who completed the audit.
c. A list of every resident name who did not have footrests on their wheelchair.
d. Observation if that resident self-propelled or was assisted by staff, and if assisted by staff if their footrests were in place when being transported.
c.) Follow up with staff if observed transporting a resident without footrests, the name of the staff and the follow up provided
3.Keep a written record of the process and audit and make available to the Inspectors immediately upon request

Grounds
1.The licensee failed to ensure a resident had footrests on when being transported in their wheelchair.

Rationale and Summary
A Critical incident report (CIR) was submitted related to an incident wherein a resident fell from their while being transported in their wheelchair without footrests, resulting in a medical injury for which they were transferred to hospital.

The home's policy on resident care equipment directs that staff are to ensure wheelchair footrests are in place and secured with resident's feet positioned on footrests prior to transporting any resident in a wheelchair.

Staff, in an interview indicated they were transporting a resident in their wheelchair with them holding their feet up when their foot dropped and went under the wheelchair causing them to fall forward out of the chair. Staff acknowledged they were not aware of the requirement of residents to have footrests at the time of the incident and that they had received training related to the use of resident care equipment, specifically footrests, following the incident.

Staff indicated the expectation of the home is that staff are to put footrests on wheelchairs any time they porter residents.

The Director of Care (DOC)acknowledged staff failed to put footrests on and the resident fell forward sustaining an injury.

Failing to ensure a resident had footrests on their wheelchair when they transported them posed moderate risk to resident when they fell and were injured.

Sources: CIR, Resident Care Equipment policy, home's investigation notes, resident's clinical health records, interviews with staff.

2.The licensee failed to ensure a resident was transported with footrests on their wheelchair.

Rationale and Summary
During an interview the Inspector and staff observed a resident being pulled backwards by a staff member while reclined in their wheelchair with no foot pedals and feet dangling close to the floor. The resident was transported from the front door down the hallway to a home unit. Staff identified the resident and indicated this is not the proper way to transport residents indicating it is the expectation of the home that foot pedals are used when transporting residents.

The following day staff were observed transporting a resident in their wheelchair from the front entrance of a home area to their seat in the dining room with no foot pedals on. The resident had a blue backpack on the back of their chair with footrests inside. Staff indicated that the resident can self-propel themselves in their wheelchair and sometimes needs help as they can get stuck.

Staff indicated the expectation of the home is that residents who require to be

portered have foot pedals and indicated it was against policy of the home for staff to be pulling a resident backwards to porter them.

Failing to ensure a resident was transported with their foot pedals on posed a risk for injury.

Sources: Observations, Interviews with staff.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #006 Housekeeping

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 93 (2)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours.

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

The licensee shall:

1. The Environmental Service Manager (ESM) will design a daily cleaning schedule for the housekeeper staff and RSA staff in the home for the days and evening shift.
2. The ESM or management designate will audit three different random rooms on each resident home area, three times weekly, to ensure the housekeeping and RSA staff are completing the daily cleaning of resident rooms as scheduled. Audits will be completed for a period of 4 weeks on day and evening shift.
3. The ESM will review the audits with the Acting Administrator, when completed after 4 weeks, and they will develop a corrective plan of action for any identified areas of non-compliance with daily cleaning of residents' rooms. The corrective plan of action, if any, will be implemented with one week of the completion of the audits.
4. Keep a documented log of all audits including dates, and plans of action, and make available to the inspector upon request.

Grounds

The licensee has failed to ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces

Rationale and Summary:
During the inspection Infection Practice and Control Practices (IPAC), housekeeping staff interviews were conducted. Housekeeping staff indicated they work 0645-1445 hours (hrs) and do not complete all of the cleaning of the residents' rooms for the unit on their shift. They also indicated that they are responsible for two units totaling forty-five to fifty-five resident rooms,, and associated common areas.
A record review indicated the housekeeping staff are to sign off on a cleaning audit on a daily basis and if the cleaning is not completed, then to indicate what was completed. The homes' Job routines indicate that the

Housekeeper and Resident Service Associate (RSA) roles indicated cleaning of resident rooms, common areas and floors.
An interview with the Environmental Service Manager (ESM) indicated that a full time and part time Janitor roles were eliminated by the former Administrator and replaced with one full time and three part time Resident Service Associate (RSA roles.).

During interviews with staff, they indicated that cleaning is not competed daily in the home and there is no cleaning audit utilized to indicate what area were cleaned. An interview with the ESM confirms that they are not aware of any missed cleaning and does not complete an environmental audit of the residents' rooms or the cleaning of the common areas of the home.

Failure to monitor the housekeeping and RSA cleaning duties in the home may pose an infection risk to residents and may contribute to resident dissatisfaction with the cleanliness of the home.

Sources: Housekeeping Cleaning Schedule Audit, Housekeeper and RSA job description, interviews with staff.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #007 Hazardous substances

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 97

Hazardous substances

s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

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

The licensee shall:

1. The Environmental Service Manager or management designate will audit every housekeeping cart on Days and Evening Shift (including weekends and holidays) to ensure that hazardous chemicals are labelled and stored securely and inaccessible to residents.
2. The Audit will occur daily on every unit on the Day and Evening Shifts, noting the date, time and location of the audit, the name of the auditor and the auditee and any corrective action being taken. This Audit, will occur daily for 2 weeks and then twice a week for 2 weeks.
3. The home will keep the audit and documented records and make available to the inspector upon request.

Grounds

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

Rationale and Summary

During a tour of the home, it was observed that a housekeeping cart was left in the hallway unsupervised with hazardous chemicals, accessible on top of the cart.

The homes' Housekeeping Cart Policy indicated that chemicals on the cart are locked and inaccessible to residents and all chemicals are labelled to their contents.

Staff confirmed that the housekeeping cart was left unsupervised and with a high-level disinfectant, and cloths inside a container labelled Hellman's Mayonnaise on top of the cart. There was a secondary label of Oxivir Plus. Staff indicated that the lid was on the Hellman's Mayonnaise container and assumed this was sufficient to keep residents safe.

Staff confirmed that they keep high level disinfection, and cloths inside a container labelled Hellman's Mayonnaise, on top of the cart, as that was the practice in the home, and no management has indicated otherwise.

Staff confirmed that all housekeeping carts in the home that contain hazardous chemicals are to be locked while unsupervised as per the home's policy.

Failing to ensure that hazardous substances were always kept inaccessible to residents, could potentially cause harm to a resident, if not handled correctly or if ingested, inhaled or absorbed.

Sources: Observations, Housekeeping Cart Policy, interviews with staff.

This order must be complied with by January 31, 2025

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

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.