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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Public Report

Report Issue Date: February 27, 2025

Inspection Number: 2025-1328-0001

Inspection Type:
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): February 5-7, 10-12, 14, 18-21, and February 24-25, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:
• Intake: #00129349, #00130938, #00134555, #00134957, #00136289, #00136681 - alleged abuse of residents by co-residents.
• Intake: #00132725, #00133722, #00134500 – alleged abuse of residents by co-residents.
• Intake: #00129383 – 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.
• Intake: #00133071 - Follow-up #: 1 - O. Reg. 246/22 - s. 97, CDD January 31, 2025
• Intake: #00133072 - Follow-up #: 1 - O. Reg. 246/22 - s. 93 (2), CDD January 31, 2025
• Intake: #00133073 - Follow up #2 - O. Reg. 246/22, s. 35 (3)(a), Compliance order #003 under Inspection 2024_1328_0003, RIF $500
•Intake: #00133074 - Follow up #2 -FLTCA 2021, s. 5 -Compliance order #001

under Inspection 2024_1328_0003, RIF $500
• Intake: #00133075 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (9) 1, CDD January 31, 2025
• Intake: #00133076 - Follow-up #: 1 - FLTCA, 2021 - s. 5, CDD January 31, 2025
• Intake: #00133077 - Follow-up #: 1 - O. Reg. 246/22 - s. 37, (1) CDD January 31, 2025
• Intake: #00133078 - Follow-up #: 1 - O. Reg. 246/22 - s. 40, CDD January 31, 2025
• Intake: #00133079 - Follow-up #: 1 - O. Reg. 246/22 - s. 35 (3) (a), CDD January 31, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #007 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 97
Order #003 from Inspection #2024-1328-0002 related to O. Reg. 246/22, s. 35 (3) (a)
Order #001 from Inspection #2024-1328-0002 related to FLTCA, 2021, s. 5
Order #002 from Inspection #2024-1328-0003 related to FLTCA, 2021, s. 6 (9) 1.
Order #001 from Inspection #2024-1328-0003 related to FLTCA, 2021, s. 5
Order #004 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 37 (1)
Order #005 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 40
Order #003 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 35 (3) (a)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #006 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 93 (2)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (h)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(h) a copy of the service accountability agreement entered into in accordance with section 22 of the Connecting Care Act, 2019;

The licensee failed to ensure a copy of the service accountability agreement was posted in the long-term care home. Observations during the initial tour identified

that the licensee's service accountability posted in the LTCH had expired.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: February 6, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure the seven-day menu was communicated to residents. Observations failed to identify that the seven-day menu was posted.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: February 5, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 3.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
3. The most recent audited reconciliation report provided for in clause 288 (1) (a) of this Regulation.

The licensee failed to ensure the most recent audited reconciliation was posted in the long-term care home. Observations failed to identify that the licensee had

posted their audited reconciliation report.

Sources: Observations; and an interview with the Administrator.

Date Remedy Implemented: February 5, 2025

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
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 for a resident was provided to the resident as specified in the plan.

A resident's care plan indicated a device was to be in place at the bedside and on when in bed. Resident was observed lying in bed, there was no device in place.

Sources: A resident's care plan and interview with a Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that the plan of care for a resident was revised when the plan was not effective.

The clinical health record for a resident indicated that a safety intervention, was implemented to alert staff if co-residents entered the resident's room. Documentation identified the co-resident entered the resident's room, without awareness of staff, on numerous occasions. Documentation identified the co-resident exhibited responsive behaviours towards the resident. Documentation failed to identify the plan of care for the resident was revised when not effective.

Sources: Clinical health record for the residents; and an interview with a Registered Practical Nurse, and the Director of Care.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

1.The licensee failed to ensure the home was kept in a safe condition. The driveway/parking lot was observed snow covered and slushy during numerous dates during the inspection. The area is an accessible area for residents, staff, and visitors.

Sources: Observations; and interviews with a Maintenance Aide, Environmental Services Manager, and the Administrator.

2.The licensee failed to ensure the home and equipment were kept in a good state of repair. An exterior light, illuminating a fire exit, was observed constantly flashing during numerous dates during the inspection. A Registered Nurse (RN) indicated the light has been flashing for weeks without repair.

Sources: Observations; and interviews with an RN, and the Maintenance Aide.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to investigate a witnessed incident of abuse of a resident by a co-resident. The clinical health record for a resident identified that staff witnessed an incident in which the resident was exhibiting responsive behaviours towards an unidentified co-resident. The Director of Care (DOC) confirmed that the incident was not investigated and could not identify who the co-resident was.

Sources: Clinical health record for a resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #008 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 report an incident of abuse of a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The clinical health record for a resident identified that the resident was witnessed exhibiting responsive behaviours towards a co-resident. The Director of Care (DOC) confirmed the incident had not been reported to the Director.

Sources: Clinical health record for the residents; and an interview with the DOC.

2.The licensee failed to report an incident of abuse of a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The clinical health record for a resident identified the resident was witnessed exhibiting behavours towards a co-resident. The Director of Care (DOC) confirmed the incident had not been reported to the Director.

Sources: Clinical health record for the residents; and interviews with an RN and the Director of Care.

3.The licensee failed to report an incident of abuse of a resident by a co-resident.

Pursuant to O. Reg. 246/22, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The clinical health record for a resident identified the resident was witnessed by staff exhibiting responsive behaviours towards an unidentified co-resident. The Director of Care (DOC) confirmed that a Registered Practical Nurse (RPN) did not report the incident to the Director.

Sources: Clinical health record for a resident; and an interview with the DOC.

WRITTEN NOTIFICATION: Restraining by administration of drug, etc., under common law duty

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 39 (3)
Common law duty
s. 39 (3) A resident may not be restrained by the administration of a drug pursuant to the common law duty referred to in subsection (1) unless the administration of the drug is ordered by a physician or other person provided for in the regulations.

The licensee failed to ensure a resident was not restrained by a drug.

Pursuant to FLTCA, 2021, s. 39 (1) Nothing in this Act affects the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to

prevent serious bodily harm to the person or to others.

Documentation identified that a resident was known to exhibit responsive behaviours. Documentation identified the resident was restrained on numerous occasions. The Director of Care confirmed that the resident was not at risk of injury to themselves or others at the time of the administration of the drug.

Sources: Clinical health record for a resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Duty to respond

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to ensure concerns of the Resident Council were responded to within 10 days of receiving them. A Manager confirmed responses by the licensee were not consistently responded to as required by the legislation.

Sources: Resident Council Meeting Minutes.

WRITTEN NOTIFICATION: Duty to respond

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall,

within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee failed to ensure concerns of the Family Council were responded to within 10 days of receiving them. A Manager indicated that the licensee has not consistently responded to the Council.

Sources: Family Council Meeting Minutes.

WRITTEN NOTIFICATION: Emergency plans

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 90 (1)
Emergency plans
s. 90 (1) Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including,
(a) measures for dealing with, responding to and preparing for emergencies, including, without being limited to, epidemics and pandemics; and
(b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency.

The licensee failed to ensure emergency plans were complied with.

Pursuant to O. Reg. 246/22, s. 11 (1) (b) - Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, is complied with.

The licensee failed to ensure emergency exits were kept free of obstructions. An emergency exit was observed blocked by snow.

Sources: Observation; Fire Safety Plan.

WRITTEN NOTIFICATION: Licensee must comply

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Compliance Order (CO) #006 from inspection #2024 1328 0003 issued on November 26, 2024, with a compliance due date (CDD) of January 31, 2025, pursuant to O. Reg. 246/22, s. 93 (2) was not complied with.

The following condition of the order was not complied:

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. The licensee failed to ensure that daily cleaning schedules for housekeeper (HSK) staff and resident service aide (RSA) included cleaning of floors in residential hallways and common areas.

Sources: Daily housekeeper staff and RSA cleaning schedules; and interviews with HSK staff and the Environmental Services Manager.

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 #013

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:
The licensee has been previously issued non-compliance pursuant to FLTCA, 2021, s. 104 (4) during inspection 2024 1328 0003, issued on November 26, 2024 as a Compliance Order.

This is the second 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: Transferring and positioning techniques

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

1.The licensee failed to ensure safe transferring techniques were utilized by staff when assisting residents. A Personal Support Worker (PSW) was observed transporting a resident in a mobility device without footrests in place. The licensee's policy 'Resident Care Equipment' directs that mobility device's footrests must be in place when staff are transporting residents.

Failure of the license to ensure safe transferring techniques were used by staff when assisting residents placed a resident at risk of harm.

Sources: Observations; clinical health record for the resident, licensee's policy; and an interview with the Director of Care.

2.The licensee failed to ensure safe transferring techniques were utilized by staff when assisting residents.

The clinical health record for a resident identified the resident had been assessed as a specific transfer and that an identified transfer/lift device was to be used as required. Documentation identified the resident was assessed to have a change in their condition, and indicated staff were directed to put the resident into bed. Documentation identified staff were unable to utilize the assessed transfer/lift device, and in turn used another transfer/lift device. A Registered Practical Nurse (RPN) identified in their documentation that the transfer/lift device used by staff was unsafe to be used with the resident. The Director of Care confirmed the actions of the staff were unsafe.

Sources: Clinical health record for the resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Personal items and personal aids

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

Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)

Personal items and personal aids

s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee failed to ensure that each resident's personal care items were labelled. Observations identified that personal care items in shared resident washrooms and a spa room not individually labelled.

Sources: Observations; and an interview with the Infection Prevention and Control Manager.

WRITTEN NOTIFICATION: Skin and wound care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i) (iv)

The licensee failed to ensure that a resident who experienced altered skin integrity post incident, received a skin assessment using a clinically appropriate assessment instrument.

Clinical records for the resident and interview with Director of Care (DOC) revealed that the resident did not have an initial skin assessment following the incident.

Sources: Clinical records for a resident, and interview with DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i) (iv)

The licensee failed to ensure that a resident who experienced altered skin integrity post incident, had their injury reassessed weekly.

Clinical records for the resident and interview with Director of Care (DOC) indicated that the resident did not have a weekly skin assessment completed for an injury.

Sources: Clinical record for a resident, and interview with DOC.

WRITTEN NOTIFICATION: Notification re incidents

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee failed to ensure a resident's substitute decision (SDM) maker was notified of a witnessed incident of abuse.

A resident was witnessed by staff abusing an unidentified co-resident. The Director of Care (DOC) indicated the incident had not been reported to the unidentified co-resident's SDM.

Sources: Clinical health record for a resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Administration of drugs

NC #019 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).

1.The licensee failed to ensure drugs were administered to a resident as prescribed by the prescriber.

Medications were observed on a dining room table in front of a resident. The

Director of Care confirmed medications were not to be left unattended with the resident.

Sources: Observations; clinical health record for a resident; and an interview with the Director of Care.

2.The licensee failed to ensure drugs were administered to a resident as prescribed by the prescriber.

Medications were observed at a resident's bedside. The Director of Care confirmed medications were not to be left unattended with the resident.

Sources: Observations; clinical health record for a resident; and an interview with the Director of Care.

3.The licensee failed to ensure drugs were administered to a resident as prescribed by the prescriber.

Medications were observed at a resident's bedside. The resident indicated they had forgotten to take their medications when they were left by the 'nurse' earlier that day; the resident was observed taking the medications as the Inspector left the resident's room. The electronic medication administration record (eMAR) identified that the Registered Practical Nurse (RPN) had signed the eMAR as administering the medications to the resident at an identified hour. The eMAR further identified that the RPN administered the same medications to the resident within minutes of the resident taking the medications., thus administering medications too close together.

Sources: Clinical health record for a resident; and an interview with the Director of Care.

COMPLIANCE ORDER CO #001 Duty to protect

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

The licensee must:

1.The Director of Care, or designated manager in collaboration with the BSO Team must review and revise the plan of care for identified residents to ensure there are strategies in place to protect a resident from abuse by the co-resident, or other resident's who exhibit identified responsive behaviours. This review is to be documented, including date of the review and any revisions, name and role of those who participated in the review and revision of the plans of care. Documentation is to be kept and made available to the Inspector upon request.

2.The Director of Care, or designated nurse manager must provide in-person training as to the definition of 'sexual abuse' and the licensee's zero tolerance of abuse of a resident policy, to identified Registered Practical Nurses (RPNs) and an identified Registered Nurse. The training is to be documented and include, the date of the training, trainee's name and role, trainer's name and role and the content of the training. All documentation is to be kept and made available to the inspector upon request.

3.The Director of Care, or designated nurse manager must communicate to all staff the definition of 'sexual abuse' and clearly indicate the actions to be taken by staff if sexual abuse of a resident is alleged, suspected and or witnessed. The

communication is to be documented and include the date of the communication and platform used. Documentation of the communication is to be kept and made available to the Inspector upon request.

4.The Director of Care, or designated nurse manager must communicate to all the licensee's zero tolerance abuse policy and clearly indicate the actions to be taken by staff if abuse of a resident is alleged, suspected and or witnessed. The communication is to be documented and include the date of the communication and platform used. Documentation of the communication is to be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure that a resident was protected from abuse by a co-resident.

The clinical health record for a co-resident identified they exhibited responsive behaviours towards a resident on numerous occasions, over an identified period. Documentation identified the resident had not consented to the interactions. A Registered Nurse (RN) and the Director of Care confirmed the incidents occurred and that the interactions were not consensual. The licensee failed to protect the resident from abuse by the co-resident. as evidenced by non-compliance pursuant to FLTCA, s. 3 (1) 4, FLTCA, s. 6 (10), FLTCA, s. 28 (1) 2, and O. Reg. 246/22, s. 104 (4) issued within this inspection.

Sources: Clinical health record for the resident's, licensee's policy 'Zero Tolerance of Resident Abuse and Neglect Program'; and interviews with an RN and the Director of Care.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #002 Policy to minimize restraining of residents, etc.

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

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

1.The Director of Care must immediately provide in-person training to identified Registered Practical Nurses (RPNs) as to the licensee's policies surrounding 'least restraint' and 'chemical restraints'. The in-person training must be documented, including date of the training, content of the training, trainees' name and role and trainer's name and role. Documentation of the training is to be kept and made available to the Inspector upon request.

2.The Director of Care will communicate with all registered nursing staff the licensee's 'Least Restraint' and 'Chemical Restraint' policies. The communication is to be documented, and include date and platform used to communicate. Documentation is to be kept and made available to the Inspector upon request.

3.The Director of Care, or designated nurse manager in collaboration with the BSO Team must immediately review the identified resident's plan of care to ensure that planned non-pharmacological interventions are being utilized prior to the administration of pharmacological interventions. The review, and any required revisions are to be documented, including date of the review, participants name and role, and any revisions. Documentation of the review and revisions is to be kept and

made available to the inspector upon request.

4.The Director of Care, or designated nurse manager must audit the twenty-four-hour shift report daily for 4 weeks, including weekends and holidays, the audit is to focus on the administration of chemical restraints by registered nursing staff. If the audit identifies that a chemical restraint was administered to any resident's exhibiting responsive behaviors, the Director of Care or designated manager will audit further to determine if non-pharmacological interventions were utilized prior to the use of pharmacological interventions. If deficiencies are identified during the audit, the Director of Care or designated manager will implement immediate corrective action.

Grounds
The licensee failed to ensure their written policies to minimize the restraining of residents, specifically 'Least Restraints' and 'Chemical Restraints' were complied with. Documentation identified that a resident was chemically restrained on numerous occasions, by identified Registered Practical Nurses (RPN). Documentation reviewed identified that the RPN's did not comply with the licensee policies.

Sources: Clinical health record for a resident. licensee policies; and an interview with the Director of Care.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #003 Residents' Bill of Rights

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

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

1.The Director of Care, or designated manager in collaboration with the BSO Team must develop and implement a plan to ensure all resident's are protected from abuse of identified residents. The plan is to be documented and include any supporting documentation. Documents are to be kept and made available to the Inspector upon request.

2.The Director of Care or designated nurse manager will ensure plans developed for the protection of all residents by identified residents, are communicated to all staff. The communications with staff are to be documented, including date and platform used. Documents are to be kept and made available to the Inspector upon request.

3.The Director of Care, or designated manager in collaboration with the BSO Team must review identified resident's plan of care to ensure safeguards are in place to protect the residents from abuse by other residents. Documentation of the review and any revisions made are to be kept and made available to the Inspector upon request.

4.The Director of Care, or designated manager must communicate any and all revisions to plans of care for the identified residents, specifically related to safeguarding of the residents, with resident home area staff. The communication is to be documented, including date of communication and platform used. Documents are to be kept and made available to the Inspector upon request.

5. The Administrator, or designated manager must re-train all staff on the Residents' Bill of Rights specifically 'the right to freedom from abuse'. The training must be

documented, including date of the training, staff name and role and trainer's name and role. Documentation of the training is to kept and made available to the Inspector upon request.

6.The Administrator, or designated manager must communicate to all staff as to the licensee's zero tolerance of abuse policy, ensuring staff are aware of their role and responsibility in ensuring residents are protected from abuse by anyone, and immediately reporting any incidents of alleged, suspected or witnessed abuse to their manager or supervisor immediately. This communication is to be documented, including date and platform used to communicate. Documentation is to be kept and made immediately available to the Inspector upon request.

Grounds

1.The licensee has failed to ensure that a resident was free from abuse from a co-resident.

An incident of abuse involving the resident towards a co-resident occurred, and the home's Registered Nurse (RN) in charge was made aware of the incident by another RN. The resident was witnessed exhibiting a responsive behaviour leaning towards the co-resident. A manager acknowledged that the actions of the resident towards the co-resident constituted abuse.

Source: Critical incident report (CIR), resident record; and interviews with an RN, and the Clinical Coordinator.

2.The licensee failed to ensure that a resident was protected from abuse by a co-resident.

The clinical heath record for a resident identified that staff witnessed the resident exhibiting behaviours towards a co-resident. Documentation identified the resident was unable to consent to the interaction. A Registered Nurse (RN) indicated the

resident was not capable of giving consent, and the incident constituted abuse.

Sources: Clinical health records for the residents, licensee policy; and interviews with an RN, and the Director of Care.

3.The licensee failed to ensure that a resident was protected from abuse by a co-resident.

The clinical heath record for a resident identified that staff witnessed the co-resident exhibiting behaviours toward the resident. This was not the first incident between the residents. The Director of Care indicated the incident was abusive, and confirmed the resident was not consenting.

Sources: Clinical health records for the residents, licensee policy; and an interview with the Director of Care.

4.The licensee failed to ensure that a resident was protected from abuse by a co-resident.

The clinical heath record for a resident identified that staff witnessed a co-resident exhibiting behaviours towards the resident. Documentation identified the resident indicated that the co-resident had entered their room previously that shift and was sent away. Documentation identified the resident indicated they were not consenting to the interaction. This was not the first incident between the residents.

Sources: Clinical health records for the residents, licensee policy; and an interview with the Director of Care.

5.The licensee failed to ensure that a resident was protected from abuse by a co-resident.

The clinical health record for a resident identified the resident was found in a co-resident's room. Documentation identified that the resident was afraid. Documentation identified that another resident indicated to staff that they witnessed the co-resident pulling the resident into the room. Documentation identified that the resident was vulnerable to the actions of others and identified that the incident was not the first incident of alleged or witnessed abuse of the resident by others.

Sources: Clinical health record for the residents, licensee policy; and an interview with the Director of Care.

6.The licensee failed to ensure a resident right to freedom from abuse.

The internal investigation note indicated that staff witnessed a co-resident exhibit behaviours towards a resident. DOC indicated that the resident was not capable of giving consent.

Sources: CI, internal investigation documents, interview with DOC.

7.The licensee failed to ensure a resident's right to freedom from abuse.

The internal investigation note indicated that a co-resident exhibited behaviours toward a resident. The DOC indicated that the resident could not give consent and appeared unsettled after the incident.

Sources: CI, internal investigation documents, Interview with DOC.

8.The licensee failed to ensure that a resident right to freedom from abuse.

The progress note indicated that a co-resident exhibited a behaviour towards a resident. The resident appeared upset and requested assistance from staff. DOC indicated that the resident was not capable of giving consent.

Sources: CI, a resident's progress notes, Interview with DOC.

9.The licensee failed to ensure that a resident was protected from abuse from a co-resident.

The clinical health record for a resident identified that the resident was abused by a co-resident. Documentation identified the co-resident was known to exhibit behaviours towards residents. Documentation identified the co-resident was observed exhibiting behaviours towards the resident prior to the incident occurring.

Sources: Clinical health record for the residents; and interviews with an RN and the Director of Care.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #004 Plan of care

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

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

1.The Director of Care, or designated nursing manager, must review and revise identified residents plan of care to ensure there is a written plan to protect the resident from exhibited behaviours of co-residents, including but not limited to an

identified resident. The review and any revisions are to be documented, including date, time and what revisions were made. The reviewed and revised document is to be kept and made available to the inspector upon request.

2.The Director of Care must communicate the revised plan of care for identified residents with all care staff on identified resident home areas. The communication must be documented, including date, and platform used to communicate. Documentation of the communication is to be kept and made available to the inspector upon request.

Grounds

1.The licensee failed to ensure that there was a written plan of care for a resident's protection from abuse that set out the planned care for the resident.

The internal investigation note indicated that staff witnessed a co-resident exhibiting behaviours towards a resident. A review of the resident's care plan identified that there was no focus on safeguarding the resident from abuse. The DOC confirmed that there was another incident of the same nature involving the resident and would expect there would have been a written plan of care in place to protect the resident.

Sources: CI, interview with DOC, the resident's plan of care.

2.The license failed to ensure there was a written plan of care in place to safeguard a resident from abuse by others.

The clinical health record for a resident identified that staff found the resident in co-resident's room. Documentation identified that the resident was afraid. Documentation identified that this was not the first incident, in which staff had witnessed, the resident being abused by co-residents. Documentation failed to identify that safeguards were in place to protect the resident, who is vulnerable to the actions of others.

Sources: Clinical health record for the residents; and interviews with a Registered Nurse (RN).

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #005 Responsive behaviours

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

1.The Director of Care, or designated nurse manager, in collaboration with the BSO Team must review the plan of care for identified residents to ensure all exhibited behaviours have interventions in place to manage the resident's behaviour. Any intervention assessed as being ineffective are to be revised and/or alternate interventions developed and implemented. The review and any revisions are to be documented, including date of review and revision and name and role of all participants.

2.The Director of Care, in collaboration with the BSO Team are to communicate the plan of care for identified residents to all staff on the home areas where the resident resides. The communication is to be documented, including date and platform. Documentation is to be kept and made available to the Inspector upon request.

3.The Director of Care, or designated nurse manager, must develop and implement an auditing system to ensure the interventions planned are being implemented for resident's exhibiting responsive behaviours. The auditing system is to be documented, kept and made available to the Inspector upon request.

4.The Director of Care, or designated nurse manager must complete daily audits, using the developed auditing system to ensure interventions planned are being implemented when identified residents exhibit behaviours. The audits are to be completed daily, for all shifts, for 2 weeks, then twice weekly for 4 weeks. Corrective action is to be addressed with the individual staff, if identified. Audits including, the date, resident name, the exhibited behaviour, and interventions implemented, and any corrective action identified and measures taken address. All audits and corrective action are to be documented, kept, and made available to the Inspector upon request.

Grounds

1.The licensee failed to ensure strategies were implemented to respond to exhibited responsive behaviours of a resident.

The clinical health record for a resident identified the resident's behaviours had escalated. Documentation identified that the resident was assessed as needing an additional intervention and such was to be implemented to safeguard other residents. Documentation identified that the resident was witnessed exhibiting a behaviour towards a co-resident. The Director of Care confirmed that the intervention had not been implemented as planned, and potentially contributed to the incident.

Sources: Clinical health record for the residents; and an interview with the Director of Care.

2.The licensee failed to ensure strategies were implemented to respond to exhibited responsive behaviours of a resident.

The clinical health record for the resident identified the resident was assessed as needing an identified intervention in an effort to safeguard other residents. Documentation identified the intervention was not in place on identified dates. A Registered Nurse (RN) confirmed that the intervention was not consistently in place.

Sources: Clinical health record for the resident; and interviews with an RN and the Director of Care.

3.The licensee failed to ensure strategies were implemented to respond to exhibited responsive behaviours of a resident.

The clinical health record for a resident identified the resident was known to exhibit behaviours towards co-residents. Documentation identified strategies had been developed. Interventions developed were not observed during the inspection. A Personal Support Worker (PSW), and registered nursing staff indicated that the interventions identified were not in place and had not been used as interventions for some time.

Sources: Observations; clinical health record for the resident; and interviews with nursing staff.

4.The licensee failed to ensure strategies were implemented for a resident who exhibits responsive behaviours.

The clinical health record for a resident identified the resident was known to exhibited behaviours towards co-residents. Documentation identified that interventions had been developed. The resident was observed ambulating throughout the long-term care home without the identified intervention being

implemented. A Registered Nurse (RN) confirmed that staff were to follow developed interventions, and such were not consistently followed.

Sources: Clinical health record for the resident; and an interview with a Registered Nurse.

5.The licensee failed to ensure that strategies were developed and implemented for managing a resident's responsive behaviours. A resident was observed exhibiting a behaviour towards a co-resident on identified occasions. Documentation identified interventions were not effective.

Sources: Progress notes, care plan, and interview with DOC.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #006 Responsive behaviours

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

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

1.The Director of Care, or designated nurse manager will develop and implement a

plan to respond to the exhibited behaviours of identified residents, including reassessment of the resident and the resident's response to planned interventions. The plan is to be documented and communicated to all staff scheduled to work on the home area where the resident resides.

2.The Director of Care, or designated manager will conduct daily audits of the behaviours exhibited by identified residents, and their response to interventions. If interventions were not effective, the Director of Care in collaboration with the Physician, and BSO Team will reassess interventions and need for external supports. Audits will be conducted daily for 2 weeks.

3.The Director of Care, or designated nurse manager must provide in-person training to all registered staff as to the documentation of a resident's exhibited behaviours, triggers as identified, interventions implemented and the resident's response. The training is to be documented including date of the training, content trained upon, trainee name and role and trainers name and role. Documentation is to be kept and made available to the Inspector upon request.

4.The Director of Care, or designated manager must communicate expectations to all registered nursing staff as to what action they are to take if a resident is exhibiting a responsive behaviour and planned interventions are not effective. The communicated is to be documented, including date, and platform used. Documents are to be kept and made available to the Inspector upon request.

Grounds

1.The licensee failed to ensure that interventions for a resident exhibiting a responsive behaviour were reassessed when they were not effective.

The clinical health record for a resident indicated that an intervention had been implemented to alert staff when the resident exited their room. Documentation identified the resident exited their room, entered a co-resident's room on more than

one occasion and was witnessed by staff exhibiting behaviours towards the co-resident. A Registered Nurse (RN) indicated that the intervention was ineffective.

Sources: Clinical health record for the residents; and interviews with an RN and the Director of Care.

2.The licensee failed to ensure that interventions for a resident exhibiting a responsive behaviour were reassessed when they were not effective.

The clinical health record for a resident identified the resident exhibited behaviours. Documentation identified staff found a co-resident in the resident's room. Documentation identified the co-resident was afraid. Another resident indicated they witnessed the resident pulling the co-resident into the room. Documentation failed to identify that interventions were reassessed, following the incident, to ensure the safety of others.

Sources: Clinical health record for the residents; and an interview with a registered nursing staff.

3.The licensee failed to ensure that interventions had been reassessed for a resident exhibiting responsive behaviours when they were not effective.

The clinical health record for a resident identified the resident was known to exhibit behaviours towards other residents. Documentation identified the resident was known to 'target' the co-resident. Documentation identified an incident where the resident was exhibiting behaviours toward the co-resident prior to the CI. Documentation failed to identify interventions had been reassessed following the incident to ensure the safety of the co-resident. A Registered Nurse (RN), and the Director of Care confirmed that the resident was unpredictable and that interventions in place were not always effective.

Sources: Clinical health record for the resident; and interviews with an RN and the Director of Care.

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #007 Housekeeping

NC #026 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
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,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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

1.The Environmental Services Manager must ensure the floors in common areas and staff areas are kept clean.

2.The Environmental Services Manager must develop and implement housekeeping schedules for the cleaning of the floors in common areas and staff areas. The schedule for the cleaning of floors must be a designated task and clearly define what staff are responsible for the cleaning of the floors and when this task is to be completed. The schedule for the cleaning of the floors is to be documented and kept for review by the Inspector as requested.

3.The Environmental Services Manager must communicate the floor cleaning schedule to all housekeeping staff and any other staff involved with or assigned to housekeeping tasks. This communication must be documented and include date of the communication and platform used. Documentation must be kept and made available to the Inspector upon request.

4.The Environmental Services Manager or the Administrator will communicate with the Resident and Family Councils as to housekeeping schedules that have been development and implemented to ensure the home, including floors in common areas are being cleaned. The communication must be documented, including the date of the communication and platform used to communicate. Documentation must be kept, including any responses from the Councils, and made available to the Inspector upon request.

Grounds
The licensee failed to ensure procedures were developed and implemented for cleaning of common areas, specifically floors in resident home areas, and other common areas within the long-term care home. Housekeeping schedules and the Resident Service Aide (RSA) schedules were reviewed as part of a Follow-Up Order, the schedules failed to identify cleaning of the floors in resident home areas and other common areas. Concerns, regarding the cleanliness of the floors in the long-term care home were voiced by Resident and Family Council. The Environmental Services Manager indicated that floor cleaning in common areas was assigned to staff on an 'as needed' basis only.

Sources: Cleaning Schedules for housekeeping and RSA; and interviews with a resident, Housekeeping Aides, and the Environmental Services Manager.

This order must be complied with by May 2, 2025

COMPLIANCE ORDER CO #008 Infection prevention and control program

NC #027 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)]:
The licensee must:

1.The Infection Prevention and Control (IPAC) Manager must provide in-person training to identified Personal Support Worker (PSWs) as to the proper application of an identified PPE. The training must be documented, and include, date of the training, trainee's name and role, and the content of the training. The documentation must be kept and made available to the Inspector upon request.

2.The IPAC Manager must provide in-person training to identified PSWs as to the licensee's IPAC policy surrounding 'droplet-contact' precautions to be taken, especially when the long-term care home is in a declared outbreak. The training must be documented, and include, date of the training, trainee's name and role, and the content of the training. The documentation must be kept and made available to the Inspector upon request.

Grounds
The licensee failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control was complied with. The IPAC Standard requires that under section 6.7 Additional Requirements, Masking - The Licensee

shall ensure that all staff, and others comply with applicable masking requirements.

Personal Support Workers (PSWs) were observed without an identified personal protective equipment (PPE) on in resident home areas; an identified PSW was interacting with a resident at the time of the observation. The long-term care home had been declared to be in an outbreak, in which a control measure was identified that the identified PPE was required to be worn by staff and others in the home.

Sources: Observations of PSWs; and an interview with the Director of Care.

This order must be complied with by April 18, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #008

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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:
The licensee has been previously issued O. Reg. 246/22, s. 102 (2) (b) as an AMP under Inspection Report #2024 1328 0002, which was issued on July 10, 2024.

This is the second 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.

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
FLTCA, 2021, s. 5
O. Reg. 246/22, s. 35 (3) (a)

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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.