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

Hamilton District
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Original Public Report

Report Issue Date: July 17, 2023

Inspection Number: 2023-1393-0005

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Henley House Limited

Long Term Care Home and City: The Henley House, St Catherines

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.08.03 14:47:02 -04'00'

Additional Inspector(s)
Lisa Vink (168)
Nishy Francis (740873)
Olive Nenzeko (C205)
Lesley Edwards (506)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 7-8, 12-16, 19-21, 23, 26-30 2023 and July 4, 2023.

The following intake(s) were inspected:

- Intake: #00001574 (CI: 2909-000023-22) related to the prevention of abuse and neglect.
- Intake: #00002580 (CI: 2909-000043-22) related to medication management.
- Intake: #00003318 (CI: 2909-000047-22) related to improper/incompetent treatment.
- Intake: #00002376 (CI: 2909-000065-22) related to the prevention of abuse and neglect.
- Intake: #00003900 (CI: 2909-000067-22) related to the prevention of abuse and neglect.
- Intake: #00005516 (CI: 2909-000071-22) related to the prevention of abuse and neglect.
- Intake: #00005559 (CI: 2909-000072-22) related to the prevention of abuse and neglect.
- Intake: #00005423 (CI: 2909-000074-22) related to the prevention of abuse and neglect.
- Intake: #00005520 (CI: 2909-000076-22) related to medication management.
- Intake: #00007323 (CI: 2909-000088-22) related to skin and wound prevention and management.
- Intake: #00013683 (CI: 2909-000100-22) related to the prevention of abuse and neglect.

- Intake: #00013947 (CI: 2909-000104-22) related to the prevention of abuse and neglect.
- Intake: #00014665 (CI: 2909-000110-22) related to the prevention of abuse and neglect.
- Intake: #00015014 (CI: 2909-000112-22) related to improper/incompetent treatment.
- Intake: #00016374 (CI: 2909-000120-22) related to improper/incompetent treatment.
- Intake: #00018341 (CI: 2909-000004-23) related to the prevention of abuse and neglect.
- Intake: #00021072 (CI: 2909-000017-23) related to the prevention of abuse and neglect.
- Intake: #00021281 (CI: 2909-000018-23) related to safe and secure home.
- Intake: #00021526 (CI: 2909-000025-23) related to the prevention of abuse and neglect.
- Intake: #00021547 (CI: 2909-000026-23) related to the prevention of abuse and neglect.
- Intake: #00022458 (CI: 2909-000028-23) related to the prevention of abuse and neglect.
- Intake: #00084560 (CI: 2909-000034-23) related to improper/incompetent treatment.
- Intake: #00085480 (CI: 2909-000043-23) related to falls prevention and management.
- Intake: #00085620 (CI: 2909-000047-23) related to improper/incompetent treatment.
- Intake: #00085876 (CI: 2909-000050-23) related to medication management.
- Intake: #00087356 (CI: 2909-000066-23) related to improper/incompetent treatment.
- Intake: #00087362 (CI: 2909-000067-23) related to improper/incompetent treatment.
- Intake: #00089437 (CI: 2909-000081-23) related to an unexpected death.
- Intake: #00084121 Complaint regarding staffing, resident care and services and housekeeping.
- Intake: #00084825 Complaint regarding responsive behaviour management.
- Intake: #00086524 Complaint regarding responsive behaviours.
- Intake: #00086675 Complaint regarding staffing and resident care and services.
- Intake: #00087661 Complaint regarding improper/incompetent care.
- Intake: #00091178 Complaint relating to air temperature.
- Intake: #00087346 Follow-up compliance order related to skin and wound prevention and management.

The following intakes were completed in this inspection: Intake #00085056 (CI #2909-000038-23), Intake #00089494 (CI #2909-000083-23) and Intake #00086635 (CI #2909-000060-23) were related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1393-0004 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Nishy Francis (740873)

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

Medication Management

Safe and Secure Home
Palliative Care
Falls Prevention and Management
Admission, Absences and Discharge
Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Residents' Rights and Choices

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)
FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that the rights of residents were fully respected and promoted, specifically to have their personal health information within the meaning of the Personal Health Information Protection Act, kept confidential in accordance with that Act.

Rationale and Summary
Clear bins were observed in the front lobby of the home. Through the side of one bin, the inspector was able to see personal health information for a resident. The Executive Director (ED) acknowledged that the bins should not be in the front lobby, and the bins were removed.

Sources: Observations, interview with the ED. **[740883]**

Date Remedy Implemented: June 15, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

A) The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident sustained falls and they required additional assistance from staff. A Personal Support Worker (PSW) reported the resident had improved since their falls and now required different assistance for some of their care needs.

The logo in the resident's room noted that they required certain assistance with a certain care need. The plan of care identified the resident required a different type of assistance for that care need and that another care need did not occur.

The plan of care was amended by a Registered Practical Nurse (RPN) following a review of the resident's status, to be consistent with the direction provided on the logo.

Sources: Plan of care, assessments, and logo for a resident, interviews with the resident, PSW and other staff. **[168]**

B) The licensee has failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provided direct care to the resident.

Rationale and Summary
The Physician's order and direction included that a resident may have up to a certain amount for a prescribed therapy. The plan of care identified the resident was to receive a different specified amount.

An RPN revised the plan on June 20, 2023, to reflect the current order and provide clear direction to staff.

Sources: Physician's orders, electronic Medication Administration Record (eMAR), progress notes and plan of care for the resident, and interview with an RPN and other staff. **[168]**

C) The licensee failed to ensure that the written plan of care for a resident set out clear directions to

staff and others who provided direct care to the resident.

Rationale and Summary
A resident was reassessed by the Registered Dietitian (RD) at which time their fluid goal was identified to be a specific amount in milliliters (mls) a day based on their usual intake. A review of the plan of care identified the resident's fluid goal was a different amount in mls.

The RD revised the plan to provide clear direction to staff related to the desired fluid goal and to be consistent with the RD assessment of the resident.

Sources: Plan of care, progress notes, and nutritional assessments of a resident and interview with the RD and other staff. **[168]**

Date Remedy Implemented: June 20, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident’s plan of care was reviewed and revised when the resident’s care needs were no longer necessary.

Rationale and Summary
A resident’s plan of care stated that they had a specified intervention in place. Observations of the resident in the home indicated there was no intervention present.

An RPN acknowledged that the resident does not currently have the specified intervention in place and that it should have been removed from the plan of care.

The resident’s plan of care was revised to reflect that the care needs had changed.

Sources: The resident’s plan of care, interview with an RPN and other staff, observations of the resident. **[740883]**

Date Remedy Implemented: June 13, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The licensee failed to ensure that that every operational or policy directive that applied to the long-term care home was carried out.

The Minister's Directive, titled Covid-19 Guidance Document for Long-Term Care Homes in Ontario, dated March 31, 2023, specified that homes must ensure that all staff, students and volunteers wear a medical mask for the entire duration of their shift indoors regardless of their immunization status.

Rationale and Summary
A staff member was observed serving food to residents in the main lobby without wearing a medical mask.

The ED and Infection Prevention and Control (IPAC) lead both acknowledged that the staff should have been wearing a mask and applied one after this was brought to their attention.

Sources: Observations in the Long-Term Care Home (LTCH), interviews with the ED and IPAC lead, Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (March 31, 2023). **[740883]**

Date Remedy Implemented: June 7, 2023

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 1.

The licensee has failed to ensure that persons who had reasonable grounds to suspect improper or incompetent care of a resident immediately reported the suspicion and the information upon which it was based to the Director.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 24 (1) 1 of the LTCHA, 2007.

Rationale and Summary
On an identified date in 2022, a PSW communicated to a Nursing Consultant (NC) and the Vice President (VP) an allegation of improper care to a resident on an identified date in 2021. The PSW indicated that the incident was reported to an Assistant Director of Care (ADOC) when it occurred.

The Director was not notified of this alleged incident until approximately three months later.

Failure to immediately report the allegation of improper care to the Director had low impact and risk to the resident.

Sources: Meeting notes, a resident's progress notes, communication from a PSW, interview with staff. **[C205]**

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth and individuality.

Rationale and Summary
A resident was using the bathroom and pulled the call bell for assistance. The resident waited for an extended period of time in the bathroom before a PSW attended to them. The PSW acknowledged the resident had to wait before care was provided to them.

The resident acknowledged they were not treated with courtesy or respect.

Sources: Investigation into the incident; CI #2909-000004-23 and interviews with the resident and ED. **[506]**

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure that a resident was provided care and services consistent with their needs.

Rationale and Summary
A resident was admitted to the home on an identified date in 2022, and shortly after started to display responsive behaviours.

From 2022 to 2023, a resident was sent to the hospital multiple times invalid reasons according to provincial guidelines.

The home has a policy that is to be put in place to attain immediate assistance in a situation related to certain behaviour. Of the several times the resident was sent to the hospital, the policy was used once.

Failure to provide the resident with care and services consistent with their needs resulted in a risk of ineffective care being provided to the resident.

Sources: Resident's clinical record; hospital discharge notes; review of the home's policy; review of provincial guidelines; interview with Physician, NP, a Director of Care (DOC), and an ADOC and other staff. **[506]**

WRITTEN NOTIFICATION: When Reassessment, Revision is Required

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary
A resident was admitted to the LTCH and began displaying responsive behaviours. In 2022, the resident had a new daily intervention implemented. The resident's responsive behaviours and new daily intervention were not added to their care plan until 2023. At the time of the inspection, some of the responsive behaviours had not been added to the care plan.

An ADOC acknowledged that the care plan, which is part of the resident's plan of care, was not updated to reflect the resident's behaviors and new daily intervention.

Failing to ensure that the plan of care was reviewed and revised when the resident's care needs changed, put co-residents, staff, and visitors at risk.

Sources: Observations of the resident, the resident's clinical record, interview with an ADOC, and other staff, CI #2909-000034-23, the home's policy. **[740883]**

WRITTEN NOTIFICATION: Policies, etc., to be Followed, and Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (a)

The licensee has failed to ensure that there was an organized program of nursing services that met the assessed needs of residents and that they complied with their Palliative and End of Life Care Program.

In accordance with O. Reg. 246/22, s. 11 (1) b the licensee was required to ensure that their program of nursing services met the assessed needs of residents and that it was complied with. O. Reg. 246/22, s. 61 identified that the home was to ensure that the palliative care needs of residents were met.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A request was made for the most recent palliative care committee meeting minutes and the Terms of Reference. A DOC and an ADOC identified the home did not have an active palliative care committee and were unable to locate a record of a committee for the year 2022 or to date in 2023.

Sources: the home's policy and interview with the DOC and other staff. **[168]**

WRITTEN NOTIFICATION: Duty to Protect

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

A) The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

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

A resident was injured by another resident demonstrating responsive behaviours.

Failing to protect the resident from physical abuse by another resident caused actual harm to the resident when they sustained injuries as a result.

Sources: Interview with an ADOC and other staff, resident's clinical records, CI #2909- 000100-22. **[740883]**

B) The licensee has failed to ensure that a resident was protected from verbal abuse.

Rationale and Summary
O. Reg. 246/22, s. 2. (1) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A resident stated they felt intimidated by a PSW, and this prevented the resident from using their call bell. The resident described the PSW's tone as loud and dismissive, and the interactions with the PSW as stressful, preventing the resident from using their call bell when the PSW was working. The ED confirmed the home had completed an investigation and appropriate steps were taken to rectify the situation.

Sources: Interview with the resident and ED; the home's investigative notes. **[740873]**

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that an incident of alleged physical abuse toward a resident that was reported to the licensee, was immediately investigated.

Rationale and Summary
A resident reported to the home's staff an allegation of physical abuse by a PSW resulting in an injury.

A review of clinical records confirmed that the allegation of physical abuse was communicated to a former DOC and no action was taken.

An NC, the ED, and former DOC confirmed that the incident was not investigated.

Sources: Clinical records for a resident, interview with former DOC and other staff. **[C205]**

WRITTEN NOTIFICATION: Doors in a Home

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii. A.

The licensee has failed to ensure that a door leading to an unsecured area outside of the home that residents have access to, was equipped with an audible door alarm that was connected to the resident-staff communication and response system or connected to an audio-visual enunciator that was connected to the nurses' station nearest to the door.

Rationale and Summary
The area directly outside an exit door on a resident home area was a patio which was not enclosed. The patio led to a path on the property leading to the road. Separate observations of the door and interviews with PSWs and the Environmental Services Supervisor (ESS), confirmed that when the door was opened and the audible door alarm was activated, it was not connected to the to the resident-staff communication and response system or to an audio-visual enunciator that was connected to the nurses' station nearest to the door.

There was risk of harm to wandering residents accessing an unsecured area without staff awareness.

Sources: Observations of the door, interviews with a PSW and other staff, the home's policy. **[740873]**

WRITTEN NOTIFICATION: Communication and Response System

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

A) The licensee has failed to ensure that the resident-staff communication and response system could be accessed by residents, staff and visitors at all times.

Rationale and Summary
The ESS notified an ADOC that a resident's call bell had been disconnected causing it to break. The licensee investigated and found that for a period of six days, the resident did not have access to a call bell.

Sources: Call bell log, CI #2909-000066-23, interview with an ADOC. **[740883]**

B) The licensee has failed to ensure that the resident-staff communication and response system could

be accessed by residents, staff, and visitors at all times.

Rationale and Summary
Registered staff identified that a resident's communication and response system at the bedside was not functioning. The ESS identified that the call bell wire was disconnected and broken. The ESS was able to fix the communication and response system at that time. The licensee completed an investigation and found that the resident's call bell was not functioning for less than 24 hours.

Failure to ensure that the resident-staff communication and response system was accessible at all times had the potential to prevent the resident or staff from alerting others that they were in need of assistance.

Sources: CI 2909-000067-23; call bell log history; interview with the ESS and other staff. **[506]**

WRITTEN NOTIFICATION: Cooling Requirements

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (1)

The licensee has failed to comply with their written heat related illness prevention and management plan.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee was required to ensure that the heat related illness prevention and management plan was complied with.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A review of Daily Air Temperature and Humidity Records noted seven occasions where the temperature recorded in one or more areas of home was 26 degrees or greater.

The acting ESS confirmed they were not immediately notified of the temperature readings in the home when the values were 26 degrees C or greater.

Failure to notify the ESS when the temperature in the home was at least 26 degrees C had the potential to delay the implementation of interventions for residents, if needed.

Sources: A review of the home's policy and Daily Air Temperature and Humidity Records, and interview

with the acting ESS and other staff. **[168]**

WRITTEN NOTIFICATION: Air Temperature

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure that temperatures outlined in section (2) were measured and documented once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
O. Reg. 246/22, s. 24 (2), identified that air temperatures were to be measured and documented in writing in one resident common area on every floor of the home.

A month of Daily Air Temperature and Humidity Records were reviewed. The records were incomplete for air temperature readings for a common area on the second floor on nine occasions in total in the afternoon between 12 p.m. and 5 p.m. or during the evening/night.

Failure to record air temperatures in accordance with the requirements had the potential for the home not to initiate their heat related illness plan for residents, if required.

Sources: Daily Air Temperature and Humidity Records and interviews with the ED and other staff. **[168]**

WRITTEN NOTIFICATION: Plan of Care

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment with respect to safety risks.

Rationale and Summary
A resident was seen by an outside service with recommendations that a plan be developed. A DOC documented the recommendations from the report being received.

No assessment had been completed and no plan developed for the resident.

Failing to complete an interdisciplinary assessment of the resident may have prevented staff of being aware of the possible safety risks.

Sources: Resident's clinical record; outside resource referral, and interview with DOC and other staff. **[506]**

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary
A resident was having care provided to them by a PSW and the resident rolled out of bed to the floor. Review of resident's plan of care indicated that they required a certain amount of assistance for bed mobility. An ADOC acknowledged staff did not use safe positioning techniques when providing care to the resident.

By not following the resident's plan of care and not using safe positioning techniques the resident was placed at risk for harm.

Sources: Resident's clinical record; CI 2909-000112-22; the home's investigation notes and interview with an ADOC. **[506]**

WRITTEN NOTIFICATION: End-of-Life care

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 46

The licensee has failed to ensure that a resident received end-of-life care when required in a manner that met their needs.

Rationale and Summary
A resident had a deterioration in status. The resident's Substitute Decision Maker (SDM) and Medical Doctor (MD) supported a palliative approach to end-of-life care at which time End of Life Orders were written which included routine and as needed pain medication for comfort. The SDM requested medications to be administered by a specified route; however, the orders written was for the medication(s) to be given by another route.

Pain medications were not administered during the day shift, nor was the MD contacted to change the

route of administration until around 1400 hours, after additional requests were made by the SDM.

A Registered Nurse (RN) identified that pain medication was first administered the same day at approximately 1515 hours; however, records were not fully completed related to the time of administration.

Failure to provide the resident with end-of-life care, when required in a manner consistent with their needs had the potential to result in unnecessary discomfort for the resident and actual dissatisfaction for their SDM.

Sources: Review of clinical health record for the resident, review of staff interview statements, review of written letter of complaint and response, review of staff human resource files and interviews with an RN and other staff. **[168]**

WRITTEN NOTIFICATION: Required Programs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)

The licensee has failed to ensure that the pain management program provided assessment instruments for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the pain management program provides for assessment and re-assessment instruments, and is complied with.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident had an altercation with a co-resident and sustained injuries. The next day, the resident voiced that they had pain where they had sustained one of the injuries.

An RN confirmed that a specific assessment was to be completed when a resident demonstrated a new onset of pain, and that it was not completed for the resident.

There was a minimal risk posed to the resident when their new onset of pain was not assessed using a comprehensive pain assessment.

Sources: Interview with an RN and other staff, the resident's clinical record, the home's policy, CI #2909-000100-22. **[740883]**

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure the home's falls prevention and management program which provided for strategies to reduce or mitigate falls, including the monitoring of residents, was followed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and that it was complied with.

Specifically, staff did not comply with the home's policy.

Rationale and Summary

i. A resident sustained numerous falls on the same day at different times. One fall resulted in an injury to their head, some of the falls were not witnessed, and the resident was on a specific medication at the time of the falls. The HIR required staff to assess the resident every 30 minutes for one hour, every hour for three hours and then subsequently as per the schedule. An HIR form was in the clinical record and although the form was not dated it was consistent with the events of the day. The HIR assessment was completed at certain times before the resident went out of the LTCH. The HIR was not restarted when the resident sustained another fall. A PSW reported the resident had hit part of their body during this witnessed fall. The HIR was not completed on the resident's return to the home nor following the unwitnessed falls.

ii. Occurrence notes for some of the falls included an assessment of the resident's temperature, pulse, respirations, and blood pressure; however, did not include an assessment of their oxygen saturation levels. Vital signs including an oxygen saturation level were only recorded once despite numerous falls during that time.

iii. The record did not include any post fall huddles completed. A DOC identified that huddles were not put into place until after that date, despite the procedure.

Failure to follow the Falls Prevention procedure had the potential for unknown injuries, contributing factors, or the implementation of additional interventions to be identified in a timely fashion.

Sources: Review of the home's policy; review of clinical records of the resident and interviews with a DOC and other staff. **[168]**

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and where the condition or circumstance required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
A resident sustained multiple falls on the same day. One fall resulted in an injury and the initiation of a head injury routine (HIR). Numerous falls were unwitnessed.

A specific post-fall assessment was the clinically appropriate falls assessment instrument to be used post fall. The clinical record included only one initiated assessment and the tool was incomplete for a number of areas including a description of the fall. Following one fall the resident was transported to the hospital as they demonstrated a change in condition.

Failure to assess the resident with a clinically appropriate post fall assessment instrument had the potential for changes in the resident's care needs to not be identified in a timely fashion or additional interventions to be considered or implemented as appropriate.

Sources: Clinical record including progress notes and assessments of the resident, observations of the resident, and interviews with a DOC and other staff. **[168]**

WRITTEN NOTIFICATION: Skin and Wound Care

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff within 24 hours of their admission.

Rationale and Summary
A resident was admitted to the LTCH on an identified date. An RPN documented in an admission assessment that the resident had an alteration in skin integrity. There was no description of the alteration in the assessment.

An ADOC acknowledged there should have been an initial wound assessment within 24 hours of admission completed in their clinical record for the identified alteration.

Failing to complete a skin assessment within 24 hours of the residents admission put the resident at risk of staff being unaware of potential skin deterioration.

Sources: The resident's clinical record, interview with an ADOC and other staff, CI #2909-000088-2022, home's investigation notes. **[740883]**

WRITTEN NOTIFICATION: Skin and Wound Care

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
A resident had an altercation with a co-resident and sustained an injury. An ADOC acknowledged there should have been an initial skin assessment completed in their clinical record for the identified injury and that this was not done.

Failing to complete a skin assessment led the resident to be at risk of potential worsening skin conditions.

Sources: A resident's clinical record, interview with an ADOC and other staff, interview with the resident, CI #2909-000100-22. **[740883]**

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)

The licensee has failed to ensure that a resident had sufficient changes to their continence care products to remain clean, dry and comfortable.

Rationale and Summary
A resident acknowledged they were not provided continence care for several hours on an identified date and remained in a soiled incontinence product and soiled wheelchair. A staff member documented that they provided care to the resident during those hours and acknowledged to an ADOC they had not. An ADOC completed an investigation and confirmed the staff member had not provided care to the resident during those hours. A PSW that was working in the home area during those hours confirmed the resident appeared to have not received continence care and provided the required continence care.

Sources: Interview with the resident, a PSW, an ADOC; resident's clinical record, home's investigative notes. **[740873]**

WRITTEN NOTIFICATION: Responsive Behaviours

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1)

The licensee has failed to ensure that the home's responsive behaviours program was developed and implemented to meet the needs of a resident with responsive behaviours.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a responsive behaviours program that met the needs of residents with responsive behaviours.

Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident was admitted to the LTCH and displayed responsive behaviours. For a period of numerous months, the resident was sent to the hospital for assessment on multiple occasions. Of the multiple hospitalizations only one resulted in a change to their plan of care.

The home did not utilize available community supports available to the resident in a timely fashion to manage their needs and responsive behaviours. Hospital staff had a meeting with the management of the home in an effort to explore other strategies and resources available to the resident. Following these meetings, referrals were submitted by the LTCH on behalf of the resident to outside resources.

A DOC and an ADOC acknowledged they presently had a trained staff member in a specific area; however, this staff member did not provide any support or advice to staff to support the resident with their responsive behaviours.

Clinical record review and interviews acknowledged that the home did not complete assessment tools to assess the resident's behaviours to assist in care planning.

Failure to follow the Responsive Behaviour procedure resulted in repeated hospitalizations and increased the risk of harm to other residents, staff, and visitors and not managing the resident's responsive behaviours.

Sources: Review of the home's policy; review of clinical record for the resident and interviews with a DOC and other staff. **[506]**

WRITTEN NOTIFICATION: Palliative Care

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)

The licensee has failed to ensure that the interdisciplinary assessment of a resident's palliative care needs for their plan of care considered the resident's physical and emotional needs.

Rationale and Summary
A resident had a deterioration in status. The resident was assessed with specific scale and had an identified score. An assessment was also initiated at this time for suspected pain.

The resident's SDM and Physician supported a palliative approach to end-of-life care at which time End of Life Orders were received.

The clinical record identified that the resident was not assessed, when identified to be palliative, for their physical and emotional needs, despite the changes to their treatment plan.

Failure to complete an assessment of the resident related to their palliative care needs had the potential for care needs to be unmet.

Sources: Review of records of the resident including assessments, plan of care, Physician's orders, review of interviews and Human Resource files of staff and interviews with an RN and other staff. **[168]**

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection and application.

LTCH inspector observed two PSWs come out of a resident's room that was under additional precautions. Both PSWs were not wearing any type of PPE required for the additional precautions. Both PSWs acknowledged that they had been providing personal care to the resident, and they were not wearing the required PPE.

Failing to apply PPE posed a risk of spreading infection to other residents.

Sources: Observations of PSW staff, interview with PSW staff. **[740883]**

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that on every shift, symptoms indicating the presence of infection were recorded and that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Specifically, staff did not comply with the home’s policy.

Rationale and Summary
A resident began to display signs and symptoms of an infection, and a specified amount of days later the

symptoms were documented as resolved.

The IPAC lead confirmed that there was no documented recording of the resident's symptoms during any shift for some of the days the infection was present.

Failing to record the resident's symptoms every shift put the resident at a risk of worsening symptoms being undetected.

Sources: Interview with the IPAC lead, a resident's clinical record, the homes policy. **[740883]**

WRITTEN NOTIFICATION: Dealing with Complaints

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the nature of a written complaint.

Rationale and Summary
A written complaint was sent to the ED. The home's policy indicated that the ED must keep a documented record that included what the contents of any written complaint were.

The ED acknowledged they did not keep a documented record that included the nature of the written complaint.

Sources: Interview with the ED, written complaint, the home's policy, home's complaint log. **[740883]**

WRITTEN NOTIFICATION: Dealing with Complaints

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve a complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary
A written complaint was sent to the ED. The home's policy indicated that the ED must keep a documented record that included the type of action taken to resolve the complaint, including the date

of the action, time frames for actions to be taken and any follow-up action required.

The ED acknowledged they did not keep a documented record that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

Sources: Interview with the ED, written complaint, the home's policy, home's complaint log. **[740883]**

WRITTEN NOTIFICATION: Dealing with Complaints

NC #031 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included the final resolution of a complaint.

Rationale and Summary
A written complaint was sent to the ED. The home's policy indicated that the ED must keep a documented record of the final outcome of the investigation.

The VP acknowledged that the home did not have a documented record of the final outcome of the investigation into the complaint.

Sources: Interview with the VP, written complaint, the home's policy, home's complaint log, CI #2909-000067-22. **[740883]**

WRITTEN NOTIFICATION: Dealing with Complaints

NC #032 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record, regarding complaints, was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary
A resident voiced a concern to the VP of the licensee which was documented.
The incident was investigated, and actions were taken in response to the concern.

A review of the complaint records available did not include documentation that there was a response to the resident regarding their concern.

Failure to maintain a record of the response provided to complainants regarding their concerns had the potential for issues to be left outstanding and a dissatisfied resident.

Sources: Progress notes of the resident, complaints log, investigation notes, Complaints Investigation Form, Critical Incident report and interviews with the resident, the VP, and other staff. **[168]**

WRITTEN NOTIFICATION: Medication Management System

NC #033 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home were implemented.

Rationale and Summary
A) A resident returned to the home from the hospital. Part of the resident's discharge orders from the hospital included a specific medication to be taken once daily for a set amount of days.

An RPN completed the medication forms when the resident returned to the home but did not include the specific medication in the orders.

The home's policy at the time titled Medication Reconciliation indicated that the nurse should enter all the readmission medications on the Admission Medication Reconciliation form. The VP acknowledged that the home's policy was not implemented.

Failing to not follow the written policies in regards to medication reconciliation led the resident to be at risk of potential worsening health conditions.

Sources: Home's investigation notes, CI# 2909-000076-22, a resident's clinical record, interview with the VP, the home's policy. **[740883]**

B) A resident returned to the home from the hospital. Nine days later, an RPN discovered the resident's Medication Reconciliation was not processed since their return to the home. A Pharmacy Technician stated the Pharmacy received the Medication Reconciliation the day it was discovered. The resident did

not receive medications in accordance with the directions for use as specified by the prescriber for nine days.

Sources: Interview with an RPN; review of the resident's clinical record, home's policy. **[740873]**

WRITTEN NOTIFICATION: Emergency Drug Supply

NC #034 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 132 (b)

The licensee has failed to ensure that where a home maintains an emergency drug supply their written policy related access to the supply and the use of drugs in the supply was complied with.

Specifically, staff did not comply with the GeriatRx policy Emergency Stat Box.

Rationale and Summary
A resident had a change in condition and was ordered end of life medication including a pain medication. The initial order was for a certain administration route; however, the resident's needs required the medication be administered by a different route.

The Physician was contacted regarding this concern and a new order was anticipated on the arrival of the Physician to the resident's home area. In anticipation of the Physician's order an RN removed a form of the pain medication from the emergency stat box, without an order, as required in the procedure, and provided it to another RN.

Failure to follow the policy had the potential for a medication error.

Sources: Review of the home's policy, the resident's clinical record and interviews with an RN and other staff. **[168]**

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #035 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 136 (1) (d) (i)

The licensee has failed to ensure that the written policy developed in the home for the ongoing identification, destruction and disposal of a resident's drugs when the prescriber attending the resident ordered that the use of the drug be discontinued was complied with.

On April 11, 2022, the FLTCA, 2021 and O. Reg. 246/22 came into force, which repealed and replaced the LTCHA and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 136 (1) (d) (i) of O. Reg. 79/10.

Specifically, staff did not comply with the licensee's policy.

Rationale and Summary
A resident was administered a medication from the medication cart, which was previously discontinued by the prescriber. The medication incident report and an RPN identified that the medication was still in the medication cart at the time of administration.

Failure to follow the policy contributed to a medication error.

Sources: Review of the home's policy, review of medication incident report, review of the resident's clinical record and interview with an RPN and other staff. **[168]**

WRITTEN NOTIFICATION: Administration of Drugs

NC #036 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident.

Rationale and Summary
A resident demonstrated responsive behaviours. In response to the behaviours, an RPN administered a medication to the resident which was obtained from the medication cart and labelled for the resident.

The eMAR did not include directions for the use of that medication.

Physician's orders dated previously included that the medication, previously prescribed for the resident, was discontinued.

Administering a drug to a resident which was not prescribed for them had the potential for the resident to experience undesired effects.

Sources: The resident's clinical record and interview with an RPN and other staff. **[168]**

COMPLIANCE ORDER CO #001 Plan of Care

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

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

The licensee shall:
1. Provide education for all Registered Nursing Staff and Personal Support Workers on the Centennial Home area, as well as the home's Responsive Behaviour Lead on:
- A resident's triggers to their responsive behaviours; and
- The home's responsive behaviour policy; and
- The importance of ensuring triggers are identified in the written plan of care for any residents who exhibit responsive behaviours; and

2. Document the education, including the date it was held, the staff members who attended and the staff's signatures that they understood the education; and
3. The home must keep a record of this education for the LTCH Inspector to review.

Grounds
A) The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident that included a certain intervention.

Rationale and Summary
A resident required a specific intervention. A PSW acknowledged that it was the responsibility of the PSW staff to assist with the intervention.

The home's policy indicated that assistance for the intervention was to be done by PSW staff and should have been written in the resident's clinical record.

The resident's clinical record indicated that the assistance with the intervention was not added. An ADOC acknowledged it should have been added and was not written in the resident's plan of care.

Failing to ensure that the written plan of care for the resident included assistance with the intervention, put the resident at risk of not receiving appropriate care.

Sources: Interview with an ADOC and other staff, the resident's clinical record, the home's policy. **[740883]**

B) The licensee has failed to ensure that the written plan of care for a resident, set out the planned care for the resident that included identified triggers to their responsive behaviours.

Rationale and Summary
A resident had recurrent responsive behaviours. The resident had been involved with an outside resource since shortly after admission on an identified date in 2022, and they continued to see the resident regularly from that day forward. The outside resource documented in the progress notes several triggers to the resident's responsive behaviours.

On an identified date in 2023, the home conducted a meeting with numerous members of the interdisciplinary team present. The documentation in the progress notes of the meeting indicated that the plan of care would be updated to include certain identified potential triggers.

The home's policy indicated that each resident demonstrating responsive behaviors would have a resident focused care plan developed and maintained that included triggers to the behaviour. The resident's written plan of care did not include these triggers to their responsive behaviours.
Staff indicated they were unaware of any triggers to the resident's responsive behaviours.

An ADOC acknowledged that the triggers were identified in the resident's progress notes, and that not all direct care staff have access to progress notes. An ADOC acknowledged that the triggers to the resident's responsive behaviours should have been included in the resident's written plan of care to help direct the resident's care.

Failing to ensure that there was a written plan of care for the resident's identified triggers to their responsive behaviours, put co-residents, staff, and visitors at risk.

Sources: Interview with ADOC and other staff, the resident's clinical record, the home's policy, CI #2909-000034-23. **[740883]**

This order must be complied with by: August 25, 2023

COMPLIANCE ORDER CO #002 Duty of Licensee to Comply with Plan

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

1. Create a written process to ensure that when orders are received with follow-up instructions, they are completed as required; and
2. Ensure that the process includes quarterly audits that include any discrepancies noted, how they were fixed, a corrective action plan and education to the staff who made the discrepancy; and
3. The home must keep a record of each process and any audits done for the LTCH Inspector to review; and
4. Two RPNs receive education on the home's expectation for processing Physician's orders; and
5. The home shall maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet indicating that both RPNs completed the education.

Grounds

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

Rationale and Summary
A resident had a Physician's order for a specific intervention to be changed at a certain frequency.

According to the resident's clinical record and internal investigation, the resident's intervention was not changed at the specified frequency, as set out in the plan of care.

Failure to change the resident's intervention as prescribed had the potential for the resident to experience undesired signs or symptoms.

Sources: The resident's clinical record and interview with the resident and staff. **[168]**

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

Rationale and Summary
A complaint alleged that there was a delay in care to a resident resulting in transfer to the hospital with a change in status.

The resident's clinical records identified that they had an order written for a specific intervention. A review of the home's investigation notes revealed that two RPNs did not follow the order as prescribed and that the order was not followed until five days later.

One RPN confirmed that they did follow the prescribed order. A DOC acknowledged the resident's care was not provided as specified in their plan of care.

Failure to process the order for the specified intervention as prescribed delayed the assessment results.

Sources: Investigation notes, resident's clinical records, complaint, interview with an RPN and DOC. **[C205]**

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

Rationale and Summary
The Physician wrote an order for a resident to increase a certain medication, with follow up after an identified time frame and re-assess.

An RPN reported that the resident did not receive the identified medication for a specified time frame following the initial order because there was no order to follow-up with.

A review of the clinical record identified that the medication was administered to the resident for the initial prescribed time frame and then it was stopped, and the Physician was not notified as per the order.

A DOC verified that staff failed to adhere to the resident's care plan to follow up with the Physician's order.

Failure to adhere to the resident's plan of care resulted in the resident not receiving their medication.

Sources: The resident's clinical record, interview with an RPN and a DOC. **[C205]**

This order must be complied with by: August 25, 2023

COMPLIANCE ORDER CO #003 Administration of drugs

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

The licensee shall:

1. Complete random audits twice per week for one month of medication administration for a specified resident to ensure they are receiving medication in accordance with the directions for use by the prescriber. Included in the audits should be any discrepancies noted, how they were addressed, and education provided to the staff who made the error; and
2. The home must keep a record of these audits for the LTCH Inspector to review.

Grounds

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

Rationale and Summary
A resident had scheduled medications to be given on a specified schedule. An RPN administered approximately half of five days' worth of medications to the resident. The resident was subsequently transferred to hospital.

The DOC acknowledged that the RPN did not follow the directions for use as specified by the prescriber when multiple days of medications were administered to the resident at once.

Sources: Interview with DOC, the RPN, and the resident, the resident's clinical record, home's investigation notes, CI #2909-000050-23. **[740883]**

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

Rationale and Summary
A resident was ordered several drugs to be administered on a specified schedule. A review of the resident's clinical record identified that an RN had signed off and administered the drugs to the resident.

During an investigation by the home and an interview, the RN admitted to not giving the resident's' medications on a specified date and to accidentally signing as if they had.

Sources: The resident's clinical record, home's investigation notes, interview with the RN. **[C205]**

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

Rationale and Summary
A resident was prescribed a specified medication to be given on a specified schedule. An RPN reported that the resident received half the dose of the specified medication on three occasions.

The pharmacy shipped the wrong dosage of the medication despite the sticker on the card identifying it as the prescribed dose.

An RN admitted during an interview that they administered the wrong dose of the medication to the resident but signed off that they gave the correct dose.

Failing to administer medication as per prescriber's directions put the residents at risk of potential worsening health conditions.

Sources: The resident's clinical record, Interview with an RPN and an RN. **[C205]**

This order must be complied with by: August 25, 2023

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.