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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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 23, 2025
Original Report Issue Date: May 12, 2025
Inspection Number: 2025-1227-0003 (A1)
Inspection Type: Proactive Compliance Inspection
Licensee: Medlaw Corporation Limited
Long Term Care Home and City: Pinecrest Nursing Home (Bobcaygeon), Bobcaygeon

AMENDED INSPECTION SUMMARY

This report has been amended to:
To rescind Compliance Order (CO) #001, CO #013, AMP #001 and AMP #003. CO #001 and CO #013 were replaced with a Written Notification (WN).

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9-11, 14-17, 22-25, 28-30, and May 1-2, 5-8, 2025.

The following intake(s) were inspected:
• Intake: #00143417 - Proactive Compliance Inspection (PCI)

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: 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 that the seven-day menu was communicated to residents.

The seven-day menu was observed posted in the main dining room, indicating the menu was for Week #2; the posted seven-day menu in the small dining room indicated the menu was for Week #1. The Food Services Supervisor (FSS) confirmed the menu's posted should have been for Week #2.

Sources: Seven-day menus posted in the dining rooms as of April 9, 2025; and an interview with the FSS.

Date Remedy Implemented: April 10, 2025

WRITTEN NOTIFICATION: Right to be treated with respect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure a resident was treated with respect in a way that fully recognized the resident's inherent dignity, worth, and individuality.

A resident's clinical records indicated the resident was dependent on staff for their care. The resident was observed inappropriately dressed; and on several occasions the resident was observed inappropriately groomed and positioned while in their mobility device.

Sources: Observations; a resident's clinical care records; and interviews with staff.

WRITTEN NOTIFICATION: Right to an Optimal Quality of Life

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 12.
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:
12. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

1.The licensee failed to ensure the rights of residents were fully respected, specifically the right to be given access to enjoy protected outdoor space.

The licensee's e-Communication Board identified that a resident was 'no longer able to

go outside with staff'. Interviews conducted confirmed that there was currently no plan in place to allow the resident the ability to enjoy the outdoors even with the assistance of staff.

Sources: e-Communication Board; and interviews with the Director of Care.

2.The licensee failed to ensure the rights of residents were fully respected, specifically the right to be given access to protected outdoor space for their enjoyment.

The Director of Care (DOC) indicated that any resident assessed by registered nursing staff to have a Cognitive Performance Scale of ‘3 and above’ are not permitted outdoors without staff assistance. The DOC indicated that the fenced outdoor patio is a residential area, but the area is not considered a protected space. The DOC, and the Program Manager indicated that residents who are cognitively impaired currently cannot get outdoors unless accompanied by staff, and such assistance is limited to availability of staff.

Sources: Observations; and interviews with the Program Manager and DOC.

WRITTEN NOTIFICATION: Right to quality care and self-determination

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

1.The licensee failed to ensure each resident’s personal health information was kept confidential.

Prescribed drugs were observed within sharps disposal containers with pharmacy labels attached and visible. The labelled drugs observed identified the resident's name, drug, and rationale for usage. The licensee's policy directs that appropriate measures must be implemented for the disposal of resident personal health information to prevent any unauthorized use or disclosure of information following disposal.

Sources: Observations; review of licensee policy; and an interview with a contracted service provider.

2.The licensee failed to ensure each resident's personal health information was kept confidential.

Registered Practical Nurses (RPN) were overheard reporting resident information to the oncoming staff while at the nursing station. The report could be heard, by not only the Inspector, but by non-direct care staff, and residents observed within the vicinity.

Sources: Observations.

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
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, (c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure a resident's plan of care related to responsive behaviour management provided clear direction to staff.

A resident was identified as having several responsive behaviour focuses. The interventions were reviewed. Documentation failed to provide clear directions to staff related to specific interventions.

Sources: Clinical health record for the resident, and interview with staff.

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

1.The licensee did not ensure that the outcome of bathing care set out in the plan of care was documented for a resident.

During a clinical record review there was no indication in the care records of the type of bathing the resident received.

The outcome could be a shower, bath, or sponge bath. There was no documentation to indicate what the resident received.

Sources: Clinical record for the resident; and interviews with staff.

2.The licensee did not ensure that the outcome of bathing care set out in the plan of care was documented for a resident.

During a clinical record review, there was no indication in the care records of the type of bathing the resident received.

The bathing outcome could be a shower, bath, or sponge bath. There was no documentation to indicate what the resident received.

Sources: Clinical record for the resident; and an interview with staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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, (b) the

resident's care needs change or care set out in the plan is no longer necessary.

The licensee failed to ensure a resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when the care needs change or care set out in the plan was no longer necessary.

The resident's plan of care indicated the resident had altered skin impairment. The resident's current skin assessment did not include the indicated areas of altered skin integrity.

The policy directs the staff to add/ update the care plan under the focus "skin care" identify the problem and interventions to be taken. The resident's most current assessment identified areas of altered skin impairment, but documentation failed to identify a written plan of care.

Sources: Clinical health record for the resident, and the licensee's policy.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary.

The licensee failed to ensure that the long-term care home was kept clean and sanitary.

Observations within the long-term care home identified concerns related to cleanliness and sanitary conditions of shared resident washrooms, and the tub room.

Sources: Observations; and an interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(a) evidence-based policies and procedures;

The licensee failed to ensure the infection prevention and control program must include evidence-based policies and procedures.

The long-term care home Infection prevention and control program includes a policy and procedure on Admission and Readmission of residents. This policy indicates all admissions / re-admissions will isolate in their room for an identified number of days while staff collect swabs and monitor for infectious symptoms to rule out infections.

Provincial Infectious Diseases Advisor Committee (PIDAC) Routine Practices and Additional Precautions in all Health Care Settings. Additional Precautions must be instituted as soon as symptoms suggestive of a transmissible infection are noted. The best practice guideline indicates that it is important that Additional Precautions not be used any longer than necessary and that frequent assessment of the risks of transmission be carried out by ICPs with the goal being the removal of precautions as soon as it is safe to do so due to the negative impacts for the resident.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. The IPAC Lead indicated this practice was in place prior to their role during the pandemic. There was no evidence-based reasoning or direction to the LTC home to proactively initiate additional precautions to non-sympatric individuals who are moving in or who are being readmitted into their home.

A resident was observed seated in a mobility device that was in disrepair. Their clinical records indicated the resident’s Substitute Decision Maker (SDM) voiced concerns of the appropriateness of the mobility device, and the LTC home sent a referral to the Physiotherapist (PT). The PT was unable to complete a full timely assessment to start the process of receiving a mobility device in good repair because the resident was on additional precautions. The resident was not symptomatic during this isolation period and solely isolated or put on additional precautions because they were a new

admission.

Another resident's SDM voiced concerns of the hardships the resident experienced being isolated over a week as a new admission to the LTC home.

Sources: Observations; licensee's policy, clinical health records for a resident; and interviews staff, an SDM, and a contracted service provider.

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 respond in writing to the Resident Council within 10 days after being advised of concerns or recommendations.

During a record review, it was found that the licensee did not meet the 10-day response requirement.

Sources: Record review of Resident Council meeting minutes.

WRITTEN NOTIFICATION: Licensee obligations if no Family Council

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee failed to ensure that, in the absence of a Family Council, semi-annual

meetings were convened to inform residents' families of their right to establish a Family Council.

The licensee held a town hall meeting with resident families in June 2024 via Zoom. No subsequent meetings have been convened since then.

Sources: Family communication records and staff interviews.

WRITTEN NOTIFICATION: Privacy curtains

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee failed to ensure there was sufficient privacy curtains to provide privacy in shared resident rooms.

Sources: Observations of shared resident rooms.

WRITTEN NOTIFICATION: Plan of care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 15.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions.

The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of a resident skin condition.

A resident moved into the LTC home with altered skin integrity. Documentation reviewed failed to identify a treatment plan had been developed.

Sources: Clinical record for a resident, licensee policy, and an interview with staff.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #014 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.

The licensee failed to ensure that each resident's personal care items were labelled.

Sources: Observations.

WRITTEN NOTIFICATION: Notification re personal belongings, etc.

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

Non-compliance with: O. Reg. 246/22, s. 42 (a)

Notification re personal belongings, etc.

s. 42. Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,

(a) the resident's personal aids or equipment are not in good working order or require repair.

The licensee failed to ensure that a resident's Substitute Decision Maker (SDM) was notified when a resident's personal aids or equipment needed repair.

A resident's mobility device was observed in disrepair. The clinical health record identified the mobility device was owned by the resident. The clinical health record for the resident, as well as the contracted service provider's communication and repair log, and the maintenance log were reviewed. Documentation failed to identify the resident's mobility device had been identified as needing repair, and failed to identify the resident's SDM was advised of the need for repair of the mobility device.

Sources: Clinical health record for the resident, the licensee's 'Maintenance Log', and contracted service provider's communication and repair log; and interviews with staff and a contracted service provider.

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) (e)

Skin and wound care

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

(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee failed to ensure a resident was assessed by a registered dietitian when exhibiting a skin condition that was likely to require or respond to nutrition interventions.

The clinical record for the resident indicated they were exhibiting altered skin integrity. There was no referral sent to the registered dietitian, to determine if the resident could benefit from a dietary intervention.

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

WRITTEN NOTIFICATION: Responsive behaviours

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to comply with the home's Responsive Behaviour program when managing and implementing interventions for a resident who was identified to exhibit responsive behaviours.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed to meet the needs of residents with responsive behaviours, including written strategies, techniques, and interventions to prevent, minimize, or respond to these behaviours, are followed. Specifically, the licensee failed to comply with their policy, which mandates a consistent approach to the assessment, monitoring, and management of responsive behaviours in the home ensuring the needs of residents with responsive behaviours are met.

A resident's written plan of care directed staff to potentially use physical force to provide care. The intervention was initiated. An RPN confirmed that staff would need to use physical force to complete care.

The licensee's written policy for resistance to care instructs staff not to proceed with care, to ensure resident safety, and to attempt care at a later time. The policy's written strategies did not include the application of force or restraining residents to assist with care.

By failing to comply with the program's written strategies, techniques, and interventions to prevent, minimize, or respond to responsive behaviours, the licensee put the resident at risk of harm.

Sources: Clinical health record for a resident, licensee policy; and an interview with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to identify behavioral triggers for a resident who was identifiedas exhibiting a responsive behaviour.

The clinical health record for the resident was reviewed. Documentation identified an incident between the resident and staff. Documentation failed to identify behavioural triggers related to the incident.

Sources: Clinical health record for the resident, the e-Communication Board; and interviews with the Program Manager and the DOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee failed to ensure a resident had been reassessed and interventions had been taken in response to a resident exhibiting responsive behaviours.

The e-Communication Board, and the clinical health record for a resident identified an incident which occurred; documentation indicated that the resident was no longer to go outdoors with staff. Documentation reviewed failed to identify the resident had been reassessed days following the incident and remained unable to go outdoors. The Program Manager and the Director of Care confirmed that as of this time the resident had not been reassessed; and further indicated that strategies had not been developed and or implemented to allow the resident to enjoy outdoor space.

Sources: Clinical health record for a resident, the e-Communication Board; and interviews with the Program Manager and the DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

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: 5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure foods and fluids were served at a temperature that were both safe and palatable to residents.

Tray service was observed during the inspection. Perishable soups, entrées and desserts were observed in paper bowls/cups, and within plastic containers, on plastic trays, in the kitchen. The observed plated food sat at room temperature for over an identified period of time before leaving the kitchen for delivery to residents in their rooms.

Sources: Observation of a meal service; and interviews with a dietary staff and the Food Services Supervisor.

WRITTEN NOTIFICATION: Dining and snack service

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.

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:

7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure course by course service of meals was provided to a resident.

A Personal Support Worker was observed placing a resident's dessert on the table prior to the resident finishing their entrée.

Sources: Observations during meal service; and an interview with Food Services Supervisor.

WRITTEN NOTIFICATION: Housekeeping

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (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, (b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

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

The licensee failed to ensure procedures were developed and implemented for cleaning and disinfection. Specifically, a resident's mobility device was not being cleaned and disinfected in accordance with the manufacturer's specifications.

The resident's mobility device was observed in disrepair.

The licensee's policy indicated that the cleaning and disinfecting of mobility devices are to be completed as scheduled. During a record review, there was no cleaning and disinfecting schedule implemented.

Sources: Observations; the clinical health record for the resident, and the licensee's policy.

WRITTEN NOTIFICATION: Maintenance services

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

Maintenance services

s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee failed to ensure maintenance procedures, specifically related to the monitoring of water temperature, 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's policy directs that the water temperature servicing all bathtubs, showers, and hand basins accessible to residents are to be maintained at a temperature between 40 degrees Celsius (C) and 49 C. The policy directs that action is to be taken by non-registered and registered nursing staff, as well, as the maintenance staff, if the water temperatures are identified as being below the range temperature. The licensee's 'Temperature Logs' were reviewed. Documentation identified dates where the water temperatures was less than 40 C and failed to identify that corrective action had been taken and/or documented.

Sources: Licensee's policy, Temperature Logs; and interviews with Maintenance staff, and the Executive Director.

WRITTEN NOTIFICATION: Maintenance Services

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that, (k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The licensee failed to ensure that the water temperature was monitored once per shift in random locations where residents have access to hot water.

The licensee's policy, and their Temperature Logs were reviewed. Temperature Logs failed to identify that the water temperature had been monitored once per shift, in random

locations, where residents have access to hot water. The Director of Care and the Executive Director indicated being unaware that water temperatures had not been monitored once per shift as required by legislation.

Sources: Licensee policy, and their Temperature Logs; and interviews with Maintenance staff, the Director of Care, and the Executive Director.

WRITTEN NOTIFICATION: Infection prevention and control

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure that all staff participated in the IPAC program.

Observations were made of staff placing soiled linen and clothing of a resident that was on isolation on the ground. The isolation laundry hamper was located at the non-isolated resident's bed location inside the doorway. The IPAC Lead confirmed that resident soiled clothing and linen should not be stored or placed on the ground during care.

Sources: Observations and interviews with staff.

WRITTEN NOTIFICATION: Medication Management System

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are 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.

1.The licensee failed to ensure their written policies and procedures for the medication management system 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's policy directs that, the temperature of the medication refrigerator must be always maintained between 2 degrees Celsius (C) and 8 C for proper storage of medications as recommended by the manufacturer. The policy directs, that unused, unopened medication cartridges, pre-filled pens, or vials are to be stored in a refrigerator that is maintained at a temperature 2 C to 8 C. The policy directs, that the measured temperature are to be documented daily, at minimum or as per the licensee's protocol and the 'Temperature Tracker' form. The policies direct if the fridge contains medication, and a minimum or maximum temperature is identified to be outside of the recommended range, the healthcare staff recording the out-of-range temperature must inform the supervisor for further investigation.

The medication refrigerator, in the medication room, was observed to be out of the required temperature range. The medication refrigerator contained numerous containers

of unused, and unopened medications. The 'Temperature Tracker' forms were reviewed. Documentation identified that the temperature of the medication refrigerator was not being maintained at temperatures between 2 C to 8 C, and further identified dates in which temperatures of the refrigerator were not documented. Documentation failed to identify corrective action had been taken, and or supervisor or managers notified.

Sources: Observations; the licensee's 'Temperature Tracker' forms, and licensee policies; and interviews with an RN and the Director of Care.

2.The licensee failed to ensure their written policies and procedures for the medication management system 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's policy identified that registered nursing staff are to ensure that a continuous supply of medications are available for administration by following with the re-ordering process. The policy directs that medication must be reordered when there is approximately 5-day supply remaining.

Medication Incidents identified that a Registered Nurse (RN) was unable to administer a medication as prescribed to a resident as there was an insufficient quantity of the drug on site at the long-term care home.

Sources: Medication Incidents, licensee policy; and interviews with a contracted service provider, and the Director of Care.

3.The licensee failed to ensure their written policies and procedures for the medication management system 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's policy directs that, all medications are labeled in accordance with applicable legislation and best practices for labelling as identified by the regulatory requirements. Prescription labels cannot be altered by staff. Only a registered pharmacist or physician can modify a prescription label after a medication has been dispensed.

Medication Incidents identified that a Registered Nurse (RN) directed another RN to 'pull from another resident's overstock, change the label and names, and use to administer a prescribed drug to a resident. The Pharmacy Consultant indicated that registered nursing staff are not to alter a prescription label after a medication has been dispensed, as such is considered 'dispensing' which is outside of the scope of a general class RN.

Sources: Medication Incidents, licensee policy; and an interview with the Pharmacy Consultant.

4.The licensee failed to ensure their written policies and procedures for the medication management system 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's policy directs that for, non-

pouched medications, registered nursing staff are to remove the prescription label with resident information and place for shredding; and indicated that if the label is hard to remove, staff are to use a permanent black marker to blackout resident identifier information. The empty packaging is to be discarded in an appropriate waste container. The policy directs that for, pouched medications, registered nursing staff are to use the 'water method', specifically they are to place the empty pouches into a plastic bag, add water to remove lettering, and once dissolved, the plastic bag with unidentifiable pouches can be placed in the trash, or staff may shred the empty pouches as an alternative method.

Non-pouched, and pouched medication packaging, which contained resident's Personal Health Information (PHI) were observed in waste receptacles and in sharps containers during the inspection.

Sources: Observations; licensee policy; and interviews with a contracted service provider, and the Director of Care.

WRITTEN NOTIFICATION: Administration of drugs

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to residents in accordance with the directions of the prescriber.

A resident was prescribed a drug to be administered. Documentation identified the RN could only administer a portion of the drug due to insufficient quantity of the drug being available. Hours later, another RN administered the remaining amount of the drug to the resident. Documentation failed to identify there was any communication to and/or direction from the prescriber or other Physician and/or NP. The Director of Care indicated the RNs should have contacted the physician and/or NP for direction.

Sources: Medication Incidents, the clinical health record for the resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The licensee failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain a resident's health.

Medication Incidents were reviewed. The review failed to identify that a documented record of the medication incident(s) was kept together with a record of the immediate actions taken to assess and maintain a resident's health.

Sources: Medication Incidents; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #029 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

1.The licensee failed to ensure a Physician, or a Nurse Practitioner was notified of a medication incident.

Two medication incidents, for the same date and time, identified that a resident was not administered a drug as ordered by their physician. There is no documentation in the resident's clinical health record to indicate the resident's physician and/or NP was notified of the incident.

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

2.The licensee failed to ensure that a resident's Substitute Decision Maker (SDM) was notified of a medication incident.

Two medication incidents, for the same date and time, identified that a resident was not administered a drug as ordered by their physician. There is no documentation in the resident's clinical health record to indicate the resident's SDM was notified of the incident.

Sources: Medication Incident, clinical health record for the resident; and an interview with the Director of Care.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #030 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (4) 8.

Drug destruction and disposal

s. 148 (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:

8. The manner of destruction of the drug. O. Reg. 246/22, s. 148 (4).

The licensee failed to ensure their drug destruction and disposal records, specifically for controlled substances, included the manner of destruction of the drugs.

The 'Narcotic/Controlled Medication Destruction Log(s)' were reviewed. Documentation of drug destruction failed to identify the manner in which drugs were denatured.

Sources: Narcotic/Controlled Medication Destruction Log, licensee policy; and an interview with the Director of Care.

(A1) Appeal/DREV #: 053
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Accommodation services

NC #031 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

COMPLIANCE ORDER CO #002 PASDs that limit or inhibit movement

NC #032 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 36 (5)
PASDs that limit or inhibit movement
s. 36 (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations.

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

1.Provide training to an identified manager and staff on the definition and regulatory requirements of Personal Assistance Services Devices (PASDs) to ensure resident safety. Maintain comprehensive training records, including training materials, dates, and participant details.

2.Conduct an audit to identify all residents currently using identified mobility devices. Ensure that all identified mobility devices are used in compliance with regulatory requirements and the licensee's "Restraints Policy & Procedure." Maintain documented records of the audit and provide them to Inspectors upon request. If a PASD is being used to restrain or confine a resident rather than to assist with routine activities of living, it is considered a restraint. The licensee must ensure that all restraint requirements are met in the audit.

3.Provide the required documentation to demonstrate compliance for the identified resident’s mobility device. Include all requirements mentioned in the licensee's policy under the section "Use of PASD" to the inspector(s) upon request

4.Provide the required documentation to demonstrate compliance for the identified resident’s mobility device. Include all requirements mentioned in the licensee's under the section "Use of PASD" to the inspector(s) upon request.

Grounds

1.The licensee failed to ensure that the use of a PASD was used in accordance with any requirements provided for in the regulations for an resident.

The use of a personal assistance services device (“PASD”), is to assist a resident with a routine activity of living and is not a restraining of the resident. The resident’s plan of care indicated that the resident has a mobility device for therapeutic reasons. The Director of Care and an RPN confirmed the mobility device was used to assist the resident in repositioning while in the device. The Director of Care and RPN indicated that a mobility device to assist a resident with the activity of repositioning was not

considered a personal assistance service device.

The Physiotherapist, who in the individual that assesses and orders the mobility device for residents, indicated the mobility device used for the resident was a PASD.

There was no indication of the requirements the use of the mobility device was in accordance with the regulations.

By failing to ensure the resident's mobility device was implemented as a PASD, put the resident at a safety risk

Sources: Observations, clinical records for the resident, and interview with staff.

2.The licensee failed to ensure that the use of a PASD was used in accordance with any requirements provided for in the regulations for resident #002.

The use of a personal assistance services device ("PASD"), is to assist a resident with a routine activity of living and is not a restraining of the resident. A resident's plan of care indicated that the resident has a mobility device for therapeutic reasons. The Director of Care and an RPN confirmed the mobility device was used to assist the resident in repositioning while seated in the device. The Director of Care and RPN indicated that a mobility device to assist a resident with the activity of repositioning was not considered a personal assistance service device.

The Physiotherapist, who in the individual that assesses and orders the mobility devices for residents, indicated the mobility device for the resident was a PASD.

There was no indication of the requirements the use of the mobility device was in accordance with the regulations.

By failing to ensure resident #002 tilt wheelchair was implemented as a PASD, put the resident at a safety physical and mental safety risk

Sources: Observations, clinical records for the resident, and interview with staff.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #003 Air temperature

NC #033 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

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

1.Within, 2 weeks of receipt of the inspection report and associated order, the licensee must have a certified individual inspect the incremental heating/cooling units, and or baseboard heating units in an identified resident room, and communal resident areas, to ensure the equipment is fully functioning and able to maintain air temperature within the room at a minimum temperature of 22 C; any repairs required must be completed and or the incremental unit and/or baseboard heater replaced. The inspection and any repairs must be documented and kept at the long-term care home. Documents must be made available to the inspector upon request.

2.The maintenance staff, in consultation with a contracted service provider (as required) are to inspect the windows in an identified residential space to determine if such is a contributing factor to air temperature not being maintained at 22 C. The inspection and any repairs required must be documented and kept at the long-term care home. Documents are to be made available to the Inspector upon request.

3.The Executive Director or designate are to ensure air temperatures within the long-term care home are maintained at a minimum temperature of 22 C. If temperatures are identified to be less than 22 C, corrective action must be immediately taken, and documented as to what action was taken and the outcome of such action. If the corrective action was not effective, the individual designated to measure and document the temperature must immediately contact the maintenance staff and/or manager to take further action. Documentation of the temperatures, all corrective action taken to maintain air temperature at a minimum of 22 C, and any communications to maintenance staff and/or management re: air temperature must be documented and maintained within the home. Documents must be made available to the Inspector upon

request.

Grounds

The licensee failed to ensure the long-term care home (LTCH) was maintained at a minimum temperature of 22 degrees Celsius (C).

A review of the licensee's 'Temperature Logs' identified that the long-term care home was not consistently maintained at 22 C. The Director of Care (DOC) and the Executive Director indicated being unaware of temperatures within the LTCH being below 22 C.

Failure of the licensee to ensure the LTCH was maintained at a temperature of 22 degrees Celsius poses an uncomfortable living experience for residents residing in the home, especially during the winter months, and poses gaps in Accommodation services.

Sources: Temperature Logs; and an interview with a Registered Nurse, the Director of Care, and the Executive Director.

This order must be complied with by August 1, 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 #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with 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 non-compliance pursuant to O. Reg. 246/22, s. 24 (1), under Inspection Report #2024 1227 0002, which was issued on October 17, 2024, as a Compliance Order.

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

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

COMPLIANCE ORDER CO #004 Air temperature

NC #034 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

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

1.The Executive Director, in collaboration with the Director of Care and the maintenance staff, must review the licensee's policy related to air temperature to ensure there is 'one' designated individual assigned on the day, evening and night shifts to measure and document air temperature, and responsible to initiate corrective action as required. The revised policy and any related procedures must be documented and kept within the long-term care home. Documentation must be made available to the inspector upon request.

2.The Executive Director, Director of Care or manager designate must communicate the licensee's air temperature policy and any revisions to the policy to all registered nursing staff, who are responsible to measure and document air temperature. The communication must include requirements under section 24 of the regulations, actions to be taken should air temperature be identified as being below 22 C, and the importance of communicating temperature deficiencies to maintenance staff and managers. The communication must be documented and kept within the long-term care home. Documents must be made available to the Inspector upon request.

3.The Executive Director or their identified designate must review the 'Temperature Logs' on all shift to ensure temperatures have been taken and documented in at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and every designated cooling area, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening and night. Should the review identify that temperatures have not been taken and documented immediate corrective action must be taken to rectify the situation, including but not limited to the taking and documenting of the temperature in all areas identified, under subsection 2 of the regulations, and the re-training of any required staff. All reviews, and any corrective action taken, including the re-education of staff, must be documented, and kept within the long-term care home. Documents must be made available to the Inspector upon request.

Grounds

The licensee failed to ensure temperature as required under subsection (2) was measured and documented, once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Pursuant to O. Reg. 246/22, s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home, at least two resident bedrooms in different parts of the home; one resident common area on every floor of the home, which may include a lounge, dining area or corridor; and every designated cooling area, if there are any in the home.

A review of the licensee's 'Temperature Logs' identified that the temperature within the

long-term care home (LTCH) were not consistently measured and/or documented once every day, once every afternoon between 12 p.m. and 5 p.m., and once every evening or night.

Failure of the licensee to ensure temperatures, within the LTCH, were measured and documented as directed under subsection (2) poses gaps in care and services, specifically related to Accommodation services.

Sources: Temperature Logs; and interviews with the Director of Care and the Executive Director.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #005 Compliance with manufacturers' instructions

NC #035 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1.The Director of Care, and/or their manager designate will re-communicate the licensee policy related to refrigeration of medication to all registered staff, who are responsible to measure and document medication refrigeration temperatures. The communication should emphasis the importance of maintaining temperatures within recommended ranges, the taking and documenting of corrective action, and the communication of any identified deficiency to management, and the contracted pharmacy service provider. The communication is to be documented and kept. Documentation is to be made available to the Inspector upon request.

2.The Director of Care, and/or Executive Director must develop, implement, and

document a plan to ensure registered nursing staff, who are responsible to administer medications, are following manufacturers' instructions related to the safe handling, administration, and storage of an identified drug. The plan and its implementation and communication to appropriate staff must be documented and kept. Documentation must be made available to the Inspector upon request.

Grounds

The licensee failed to ensure that all registered nursing staff use supplies, in the long-term care home, in accordance with manufacturers' instructions.

The manufacturers' instructions, for identified drugs, directs that any unopened bottles and/or medical devices should be kept in a refrigerator. The unopened drug should be stored in the refrigerator at a temperature between 36 degrees Fahrenheit (F) to 46 F (2 degrees Celsius (C) to 8 C); and directs not to freeze the drug, and in turn not to use the drug if it has been frozen.

The 'minimum' internal temperature of the licensee's medication refrigerator was identified to be outside of the normal temperature range. The refrigerator contained numerous boxes of unopened drugs. The 'Temperature Tracker' form, identified that the 'minimum' temperature of the refrigerator had been measured and documented, by registered nursing staff, as being outside of the normal temperature range for a number of days. There is no indication that corrective action had been taken.

Failure of the licensee to store drugs as per manufacturers' instructions posed risk of harm to residents, specifically related to the potential of the drug not being effective when stored incorrectly.

Sources: Manufacturers' Instructions, 'Temperature Tracker' form; and an interview with a Registered Nurse (RN) and the Director of Care.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #006 Skin and wound care

NC #036 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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,

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

1.The licensee shall gather information from the registered nursing team to identify the reasons why altered skin integrity is not being consistently assessed using a clinically appropriate assessment, including measurement and photograph upload. Document the feedback from the registered nurses and provide this documentation to the Inspector(s).

2.Development and Implementation of a plan: Based on the information gathered, the licensee shall develop, implement, and document a plan to ensure registered nurses are using a clinically appropriate assessment instrument to assess altered skin integrity. Maintain comprehensive documentation records of the plan, its implementation, and the individuals involved in the implementation.

Grounds

1.The licensee failed to ensure a resident exhibiting altered skin integrity received a skin assessment by an authorized person described using a clinically appropriate assessment instrument.

The clinical records for the resident indicated that they had altered skin integrity. The assessment was incomplete. The size and measurement of the altered skin integrity was not documented.

By failing to ensure the resident received a skin assessment when experiencing altered skin integrity, puts the resident at risk of inaccurate monitoring and treatment.

Sources: Clinical record for a resident, licensee’s policy; and interview with staff.

2.The licensee failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument specifically designed for skin and wound assessment when the resident experienced altered skin integrity.

The resident was scheduled for a weekly skin assessment. Documentation was reviewed. The review failed to identify details of the altered skin integrity as required by the licensee's policy.

By failing to ensure the resident received a skin assessment when indicated placed the resident at risk of ineffective monitoring and treatment.

Sources: Clinical records for the resident; and interviews with staff.

3.The licensee failed to ensure a resident exhibiting altered in integrity received a skin assessment by an authorized person, using a clinically appropriate assessment instrument.

The clinical health record identified that a resident had altered skin integrity. The review failed to identify the resident's altered skin integrity had been assessed using a clinically appropriate assessment tool.

Sources: Clinical health record for the resident, the licensee's policy; and interviews with Registered Practical Nurses.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #007 Skin and wound care

NC #037 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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;

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

1.The licensee shall develop, implement, and document a plan to ensure all residents experiencing altered skin integrity are reassessed at least weekly. The plan must include clear indications of when a wound has been resolved.

2.Complete an audit for identified resident's skin and wound care plans. Identify any current altered skin integrity and ensure the care plan provides clear direction to staff, including a scheduled weekly skin assessment specifically for the altered skin integrity.

Grounds

1.The licensee failed to ensure that a resident was reassessed at least weekly when experiencing altered skin integrity.

The clinical record for a resident indicated that the resident had altered skin integrity on identified dates. Documentation failed to identify the areas of altered skin integrity were resolved, and/or that clinically appropriate weekly assessments had been completed. Documentation further identified staff had not completed assessments as per the licensee's policy.

By failing to ensure weekly skin assessments were completed, the resident was put at risk of ineffective monitoring and treatment.

Sources: Clinical health record for the resident; and staff interviews.

2.The licensee failed to ensure a resident exhibiting altered skin integrity was reassessed at least weekly by an authorized person.

The clinical health record for a resident identified the resident had altered skin integrity.

A review of the clinical health records for the resident failed to identify the altered skin integrity was reassessed, at minimum of weekly, following the documented entry by a Registered Nurse.

Sources: Clinical health record for the resident, the licensee policy; and interviews with Registered Practical Nurses.

3.The licensee failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by an authorized person.

On admission to the LTC home, the resident's head to toe assessment indicated several areas of altered skin integrity.

The licensee policy directs the staff to complete a weekly skin assessment and photographs of the skin/wound issues will be taken weekly assessment and as needed. One location of altered skin integrity was a pressure wound on the coccyx. This alter skin was not reassessed for an identified number of days and was incomplete. There was no indication that the altered skin integrity was improving or deteriorating. The other locations of altered skin were not reassess using a clinically appropriate assessment.

By failing to ensure a resident was reassessed a minimum of weekly placed them at risk of a unmanaged, worsening altered skin integrity.

Sources: Clinical records for the resident, licensee's policy, and interview with staff.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #008 Skin and wound care

NC #038 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

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

The licensee must:

1.Ensure that identified residents are repositioned every two hours. Provide documentation of compliance to the Inspector(s), including the residents' care plans and the point-of-care task care records as directed in the licensee's policy.

2.Develop, implement, and document a plan to ensure all residents who are dependent on staff for repositioning are repositioned as required.

Grounds

1.The licensee failed to ensure a resident was repositioned every two hours while in a wheelchair.

The resident’s clinical records indicated that they were dependent on staff for all activities of daily living and are unable to reposition themselves.

The licensee's policy directs the staff to reposition any resident who is dependent on staff for repositioning every two hours and to document this in the e-records.

The Director of Care indicated that the staff do not document when the resident was being turned and repositioned. There was no documentation in resident’s clinical records to ensure they are being repositioned.

Sources: Clinical record for the resident; and interviews with staff.

2.The licensee failed to ensure a resident was repositioned every two hours while seated in a mobility device.

The resident’s clinical record indicated that they are dependent on staff for all activities of daily living and are unable to reposition themselves.

The licensee's policy directs the staff to reposition any resident who is dependent on staff for repositioning every two hours and to document this on e-record. The Director of Care indicated that the staff do not document when the resident was being turned and repositioned. There was no documentation in resident's clinical records to ensure they are being repositioned.

Sources: Clinical record for the resident; and interviews with staff.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #009 Food production

NC #039 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

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

1.The Food Service Supervisor, in collaboration with the Executive Director, the Registered Dietitian and/or external supports (e.g. Public Health) must review and revise all existing policy related to food temperatures to ensure such is current and reflective of best practice for food handling, taking of food and fluid temperatures including but not limited to internal temperatures for cooking and or production, holding temperatures for both cold and hot food and fluids, point of service temperatures, and reheating. The policy must include 'safe temperature zones' and any corrective action to be taken, documented, and communicated should food and fluid temperatures not be within the normal range. The review and revision of the policy, including best practice documents utilized and those who participated must be documented and kept. Documentation must be available to the Inspector upon request.

2.Any policy revisions must be communicated to all dietary staff, who are responsible for measuring, and documenting food and fluid temperatures. The communication of the policy revisions must be documented and kept. Documentation must be available to the Inspector upon request.

3.The Food Services Supervisor, or a designated individual must ensure the

temperatures, as required, for hot and cold foods and fluids have been measured and documented for items identified on the food production sheet and must ensure that corrective action is immediately taken should temperatures not be within safe temperature zones. All temperatures and any corrective action must be documented. Documentation must be available to the Inspector upon request.

4.The Food Services Supervisor, or manager designate must review the food and fluid temperatures to ensure temperatures have been measured and documented, and that if corrective action was required such was taken, documented and communicated to supervisor or managers. Should the review identify any deficiencies the Food Service Supervisor or manager designate will provide re- education/re-training to any identified dietary staff. The reviews, outcomes and any re-education/re-training of staff must be documented and kept. Documentation must be available to the Inspector upon request.

Grounds

1.The licensee failed to ensure that all food and fluids were served using methods to prevent adulteration, contamination, and foodborne illness.

During meal service observations, a PSW was seen serving crackers with bare hands between residents, and a PSW was observed serving two drinks in one hand by pinching the cups together with their fingers inside the cups.

Sources: Observations and staff interviews

2.The licensee failed to ensure that all food and fluids were kept free from contamination.

Maintenance Staff was observed standing in the kitchen, next to the food preparation table at mealtime, without a hair net on. During subsequent observations a Cook was observed entering the kitchen without a hair net on and placing their personal beverage container on the food preparation table.

Sources: Observations; and an interview with the FSS.

3.The licensee failed to ensure that all food and fluids were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

A meal service within the long-term care home was observed. Observations failed to identify that the temperatures, for both hot and cold foods, had been taken. A Cook/Dietary Aide confirmed that they had not taken the food temperatures for any foods that shift.

Failure of the licensee to ensure food temperatures were taken poses the risk of harm to residents, specifically related to food borne illness, poses gaps in care and services related to nutritional care, and potentially creates an unpleasant dining experience for residents.

Sources: Observations; and an interview with a Cook/Dietary Staff.

4.The licensee failed to ensure that all food and fluids were prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

Food production and temperature logs were reviewed. Documentation failed to identify that food temperatures had been consistently taken of hot and cold foods. The Food Services Supervisor indicated they were aware that food temperatures were not being consistently taken by dietary staff.

Failure of the licensee to ensure food temperatures were taken poses the risk of harm to residents, specifically related to food borne illness, poses gaps in care and services related to nutritional care, and potentially creates an unpleasant dining experience for residents.

Sources: Food Production and Temperature Logs and an interview with the Food Services Supervisor.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #010 Food production

NC #040 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (6) (b)
Food production
s. 78 (6) The licensee shall ensure that the home has, (b) institutional food service

equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures; and

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

1. The Food Service Supervisor, in collaboration with the Registered Dietitian and the Executive Director, must ensure the long-term care home has institutional food service equipment with adequate capacity to transport and hold perishable hot and cold foods and beverages at a safe temperature, including but not limited to, tray service. Invoices for equipment purchased must be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure the long-term care home had institutional food service equipment to transport and hold perishable hot and cold foods at safe temperatures.

Tray service was observed during the inspection. Perishable soups, entrées and desserts were observed in paper bowls/cups, and in plastic containers, on plastic trays, in the kitchen. The observed perishable food sat at room temperature in the kitchen and then was transported on an open metal cart to resident rooms.

Sources: Observations; and an interview with the Food Service Supervisor.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #011 Maintenance services

NC #041 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that, (g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

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

1.The Executive Director, in collaboration with the licensee, and the maintenance staff must ensure all hot water servicing bathtubs, showers and resident hand basins are 'fully' functioning and not able to exceed 49 degrees Celsius.

2.Ensure all water equipment servicing and regulating hot water is 'fully' functioning and free of disrepair. Should the licensee already be aware that hot water regulating systems are not fully functioning or in a state of disrepair, the licensee will immediately take measures to repair and/or replace equipment to ensure the safety and comfort of residents.

3.The Executive Director and/or their designated must recommunicate the licensee's policy related to monitoring of water temperatures to all staff, who are responsible for measuring, documenting, and taking action, should hot water temperatures exceed 49 degrees Celsius. Documentation of the communication must be documented and kept. Documentation must be made available to the Inspector upon request.

Grounds

The licensee failed to ensure the water temperature serving all bathtubs, showers, and hand basins accessible to residents did not exceed 49 degrees Celsius (C).

The licensee policy related to the monitoring of water temperature, and their 'Temperature Logs' were reviewed. The licensee's policy does direct that water serving all bathtubs, showers, and hand basins accessible to residents are to not exceed 49 C. Documentation identified numerous dates and times when the water temperature of hand basins accessible to residents had been measured and documented being above 49 C.

Failure of the licensee to ensure that water temperatures serving all bathtubs, showers, and hand basins, that are accessible to residents, did not exceed 49 C posed risk of harm to residents, specifically the potential for skin injuries/burns; and posed gaps in care and services related to Accommodation Services.

Sources: Temperature Logs, licensee's policy, 'Maintenance Water Temperatures'; and interviews with the Maintenance Staff, and the Executive Director.

This order must be complied with by August 1, 2025

COMPLIANCE ORDER CO #012 Maintenance services

NC #042 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that, (h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

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

1.Ensure residents are immediately safeguarded from hot water temperatures exceeding 49 degrees Celsius.

2.Within 1 week of receipt of the inspection report, the Executive Director, in collaboration with the Director of Care and Maintenance Staff, will develop, implement, and document a plan to safeguard residents from water temperatures exceeding 49 C, specifically within all bathtubs, showers, and residential hand basins. The plan must include 'one' designated individual on all shift to measure, document and as needed to take corrective action, should water temperatures exceed 49 C. The plan must include the communication to a supervisor and a manager. The plan must be documented and kept. Documentation must be available to the inspector upon request.

3.The Executive Director or manager designate will communicate the developed plan, and its implementation to all registered nursing staff, and or non-registered nursing staff who are identified by the licensee as responsible to measure and document water temperature within the home. The communication is to be documented and kept. Documentation must be made available to the Inspector upon request.

4.The Executive Director, in collaboration with the Director of Care and Maintenance Staff must develop and implement a plan to review water temperatures that have been measured and documented in the home, to ensure the licensee's policy and/or procedures have been followed. If the review determines deficiencies, the Executive Director or a designated supervisor/manager will provide re-training to staff identified as not following the policy.

Grounds

The licensee failed to ensure that immediate action was taken to reduce the water temperature when it was identified to exceed 49 degrees Celsius (C).

The licensee's policy, relate to monitoring of water temperature, and their Temperature Logs were reviewed. Documentation reviewed failed to identify that immediate action had been taken when the water temperature serving of bathtubs, showers, and washbasins accessible to resident were identified as being above 49 C. The Executive Director indicated awareness of water temperatures within the long-term care home being 'high', and confirmed action should have been taken to reduce water temperatures if temperatures exceeded 49 C.

Failure of the licensee to take immediate action when water temperatures exceeded 49 C in residential accessible areas posed risk of harm to residents, specifically burns; and poses gaps in care and services, related to Accommodation Services.

Sources: Licensee policy, and Temperature; and interviews with the Maintenance staff and the Executive Director.

This order must be complied with by August 1, 2025

(A1) Appeal/DREV #: 053
The following order(s) has been rescinded: CO #013

COMPLIANCE ORDER CO #013 Infection prevention and control program

NC #043 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).

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #013

COMPLIANCE ORDER CO #014 Drug destruction and disposal

NC #044 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

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

The Director of Care, in collaboration with the Pharmacy Consultant (contracted service provider), must recommunicate their policy related to drug destruction and disposal of medications, with an emphasis on the safety and handling of an identified drug, to all registered nursing staff. The communication must be documented and kept at the long-term care home. The document must be made available to the Inspector upon request.

Grounds

The licensee failed to ensure that drugs to be destroyed and disposed of were safely stored and secured within the long-term care home.

Drugs which were to be destroyed and disposed of were observed in an open sharp's container accessible to staff. The Director of Care and the Pharmacy Consultant confirmed that identified drug should not be disposed of in sharp's containers.

Failure of the licensee to ensure that drugs are safely destroyed and disposed of posed risk of harm to residents and others.

Sources: Observations of drugs for destruction and disposal; licensee policy; and interviews with a Registered Nurse, the Pharmacy Consultant, and the Director of Care.

This order must be complied with by August 1, 2025

(A1)
The following non-compliance(s) has been newly issued: NC #045

WRITTEN NOTIFICATION: Accommodation services

NC #045 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 that the long-term care home was kept in a good state of repair and good condition.

Wooden window frames, electric baseboard heaters, and privacy curtains in shared resident rooms, and common resident areas were observed in a state of disrepair.

Failure of the licensee to ensure the home and its equipment were kept a good state of repair, and safe condition poses a potentially unpleasant HOME like atmosphere for residents residing at the long-term care home.

Sources: Observations within resident rooms, and communal resident areas; and an interview with the Maintenance Staff, Director of Care, and the Executive Director.

2.The licensee failed to ensure the home and its equipment were kept in a good state of repair, and safe condition.

'Temperature Log(s)' were reviewed. Documentation identified that the hot water temperatures serving bathtubs, showers and resident hand basins were measured and documented to be above 49 degrees Celsius.

Failure of the licensee to ensure equipment within the long-term care home was in a good state of repair and safe condition poses risk of harm to residents related to unsafe water temperatures.

Sources: Temperature Logs Maintenance Log binder, quotes from external service provider; and interviews with a Registered Nurse, the Maintenance Staff, and the Executive Director.

3.The licensee failed to ensure the home was kept in a good state of repair and a safe condition.

The fencing within an outdoor patio space was observed in a state of disrepair. The Maintenance

Log binder was reviewed, and such failed to identify any planned repair of the fencing.

Failure of the licensee to keep an outdoor resident space in a good state of repair and safe condition poses an unpleasant home like environment, gaps in Accommodation services and most importantly prevents residents from enjoying a protected outdoor space.

Sources: Observations; Maintenance Log binder; and interviews with staff and managers.

4.The licensee failed to ensure the home was kept in a good state of repair and a safe condition.

Three potholes were observed on the main driveway of the long-term care home. Residents were observed utilizing the driveway for outdoor walks and/or to collect the mail from the end of the driveway. The Maintenance Log binder did not identify repair as being needed for the driveway.

Failure of the licensee to ensure the driveway was kept in a good state of repair and safe condition poses trip-fall hazards to residents and others while outdoors and poses gaps in Accommodation services.

Sources: Observations; Maintenance Log binder; and an interview with staff.

(A1)
The following non-compliance(s) has been newly issued: NC #46

WRITTEN NOTIFICATION: Infection prevention and control program

NC #46 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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).

1.The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the support for residents to perform hand hygiene prior to receiving snacks, in accordance with IPAC Standard, Additional Requirement 10.4 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard).

A Personal Support Worker entered a room with identified precautions for a resident experiencing symptoms. The Personal Support Worker provided a co-resident with nourishment without supporting the resident with hand hygiene.

A resident indicated that staff often offer hand hygiene but do not support residents during nourishment or snack time.

Sources: Observations and interviews.

2.The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the proper use of PPE, including appropriate application, removal, and disposal, in accordance with IPAC Standard, Additional Requirement 9.1 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard).

The long-term care home initiated mandatory universal masking for staff in resident home areas. However, several staff were observed wearing their masks underneath their chins in non-residential areas. Staff were also seen leaving the back entrance with their masks under their chins and returning inside the building with their masks under their chins.

The IPAC Lead indicated that the appropriate removal of a mask involves disposing of it in the garbage and completing hand hygiene. A new clean mask would be applied when required.

Sources: Observations and interviews with staff.

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.

Ontario

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

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

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