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

Hamilton Service Area Office
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Original Public Report

Report Issue Date October 31, 2022
Inspection Number 2022_1266_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Shalom Village Nursing Home

Long-Term Care Home and City
Shalom Village Nursing Home, Hamilton

Lead Inspector
Angela Finlay (705243)

Inspector Digital Signature
Angela Finlay
Digitally signed by Angela Finlay
Date: 2022.10.31 16:01:21 -04'00'

Additional Inspector(s)
Emmy Hartmann (748)
Jonathan Conti (740882)
Betty Jean Hendricken (740884)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, September 1, 2022.

The following intake(s) were inspected:
Log #004421-22, follow-up to CO#001 from inspection #2022_960695_0001 / 010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21 regarding s. 19. (1).

Log #004422-22, follow-up to CO#002 from inspection #2022_960695_0001 / 010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21 regarding s. 20. (1).

Log # 004423-22, follow-up to CO#003 from inspection #2022_960695_0001 / 010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21 regarding s. 76. (4).

Log #004424-22, follow-up to CO#004 from inspection #2022_960695_0001 / 010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21 regarding r. 215. (8).

Log #004425-22, follow-up to CO#005 from inspection #2022_960695_0001 / 010323-21, 010328-21, 010587-21, 010755-21, 015066-21, 018361-21 regarding s. 5.

Log #013580-22, was a complaint related to nutrition care, plan of care, pain management, and retaliation.

Log #008931-22, was a complaint related to falls prevention and management, and nutrition care and hydration.

Log #004119-22, was a complaint related to nutrition care.

Log #013592-22, was a complaint related to plan of care.

Log #012654-22, CIS #2775-000012-22, was related to an injury of unknown cause.

Log #013696-22, CIS #2775-000014-22, was related to an allegation of improper and incompetent treatment of a resident by staff.

Log #014331-22, CIS #2775-000019-22, was related to al allegation of resident to resident physical abuse.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s.19(1)	2022_960695_0001	001	748
LTCHA, 2007	s.20(1)	2022_960695_0001	002	748
LTCHA, 2007	s.5	2022_960695_0001	005	748

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
LTCHA, 2007	s.76(4)	2022_960695_0001	003	748

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be **CLOSED**.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	r.215(8)	2022_960695_0001	004	748

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management

- Pain Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 3 (1) (19) (ii)

The licensee has failed to ensure that resident #008's right to give or refuse consent to any treatment, care or services for which their consent was required by law was fully respected and promoted.

Rationale and Summary

Staff #133 administered a medication to resident #008. The resident and their family then submitted formal complaints to the home stating that the staff member had administered the medication regardless of the fact that the resident had adamantly refused it.

The home completed an internal investigation into the complaints which included an interview with a PSW who witnessed the incident. The PSW stated that the resident had refused the medication several times and the staff member had administered it anyways and stated that the resident needed it. The resident stated that they had informed the staff member that they did not require the medication.

Th resident had a physician order for a medication that stated it was to be administered as needed (PRN) if the resident required it. Further documentation was found to validate that the resident did not require the medication and therefore the instance did not meet the PRN requirements of the medication.

The resident was noted to be very upset and in distress over the situation. Administering the medication without consent and against the residents wishes and needs caused emotional pain.

Sources: Resident #008's clinical records; Shalom Village's internal investigation notes; Shalom Village's Abuse Policy titled, "Abuse or Suspected Abuse/Neglect of a Resident/ Abuse & Neglect Program" Reference No.: 005010.00; Critical Incident Report #2775-000014-

22; and interviews with resident #008 and staff. [705243]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there was a written plan of care for resident #012 that set out the planned care for the resident related to a medical condition.

Rationale and Summary
Review of the resident's progress notes identified that there were four instances where the resident had experienced symptoms of the medical condition.

Different staff members identified that they implemented interventions such as listening to the resident and reassuring the resident when they were having symptoms of the medical condition.

A Registered Practical Nurse (RPN) indicated that the resident had a history of these symptoms and the plan of care for this would be found in the resident's care plan.

A review of the care plan identified that there was no written plan for the resident's medical condition.

The resident may have been at risk for not getting the care they required related to their medical condition.

Sources: Resident #012's progress notes, care plan; interview with Personal Support Worker (PSW) #115, PSW #117, and RPN #114. [748]

WRITTEN NOTIFICATION: PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified.

Rationale and Summary
During a meal service resident #003 was served a specific food item. The resident approached the inspector to inform them that they were concerned and upset about being served this food as it was known this food causes them to be sick.

A review of the resident's plan of care specified that they were not to have this food.

Interviews with staff following the incident confirmed they were aware that food item was not to be served to the resident as per the plan of care.

Staff did not ensure the care set out in the resident's plan of care was provided as specified and may have placed the resident at risk for illness.

Sources: Interviews with resident #003, Cook #124, Dietary Aide #120, the Food Service Manager (FSM), the Registered Dietitian (RD); record review of care plan, progress notes, meal service notes; and meal observation. [740882]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary
The Assistant Director of Care (ADOC) identified that they covered the responsibilities of the IPAC lead in the home however this was not their primary responsibility.

There may have been an increased risk of transmission of infection in the home, as the home did not have a lead whose primary responsibility was the IPAC program.

Sources: Interviews with RN #107, and ADOC. [748]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that every alleged abuse that the licensee knows of, or was reported to the licensee, was immediately investigated.

Rationale and Summary
Review of the resident's progress notes identified that on three occasions the resident had indicated someone had physically harmed them.

An RPN identified that the above incidents were allegations of abuse and they reported them to the charge nurse when the incidents occurred.

The Interim Director of Care (DOC) identified that they were not aware of the allegations and that they kept investigations related to allegations of abuse in the internal incident binder.

A review of the home's internal incident binder identified there was no investigation related to the allegations made by the resident.

There may have been an increased risk to the resident's safety and security in the home, as their allegations of abuse were not investigated.

Sources: Resident #012's progress notes, the home's internal incident binder; and interviews with RPN #114, and the DOC. [748]

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident was immediately investigated.

Rationale and Summary
A resident and their family members had reported that the resident was frequently being denied pain medication that the resident had pro re nata (PRN) prescriptions by a specific staff member. Concerns with this staff member were documented as discussed at a resident care conference. The DOC stated that they were aware of the resident's concerns and that being withheld required pain medication would constitute as neglect.

The home's abuse policy stated that any person who has reasonable grounds to suspect abuse or neglect shall immediately report it to either the Nurse/AT HOME leader, the ADOC, or the DOC and that immediately upon notification an investigation would begin. It also stated that on the outcome of the investigation, if the employee was found guilty of abuse, appropriate action would take place such as rehabilitation of the employee or formal discipline up to and including termination.

The DOC stated that the resident's allegations of neglect had not been investigated by the home. At the time of the inspection, no formal interviews had taken place between management and the staff member regarding the resident's concerns, and the staff member continued to work.

Failing to investigate allegations of neglect may have placed the resident and others at risk for potential further neglect.

Sources: Resident #002's clinical records; the home's abuse policy titled "SUBJECT: Abuse or Suspected Abuse/Neglect of a Resident/ Abuse & Neglect Program Reference No.: 005010.00"; and interview with resident #002 and the DOC. [705243]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that an incident of abuse to resident #008 by staff and an incident of neglect to resident #002 by staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Rationale and Summary

A) Complaints were made to the home by resident #008 and a family member alleging staff to resident abuse. The DOC became aware of the situation but did not report the incident to the Director until five days after the incident occurred.

Sources: Resident #008's clinical records; Shalom Village's internal investigation notes; Critical Incident Report #2775-000014-22; and interviews with resident #008 and staff. [705243]

B) Resident #002 and their family members had complained that the resident was frequently being denied pain medication that the resident had prescriptions for by a staff member.

The DOC stated that they were aware of the resident's concerns and that being withheld required pain medication would constitute as neglect. They also stated that it was not reported to the Director as they were new to the position and did not realize it was required at the time.

Sources: Resident #002's clinical records; and interview with the DOC. [705243]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s.184 (3)

The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, when they did not complete IPAC audits every two weeks while not in outbreak.

Rationale and Summary

According to the Minister's Directive: COVID-19 response measures for long-term care homes, licensee's were to comply with the Guidance Document for Long Term Care Homes in Ontario, and must complete IPAC audits every two weeks when the home is not in outbreak, and weekly when the home is in outbreak.

There was a gap of 14 weeks, two weeks and another 11 weeks where the home's IPAC audits were not completed.

The home had three COVID-19 outbreaks in the timeframes of the above gaps, lasting an average of four weeks each, and at which time, the home should have conducted weekly IPAC audits.

The ADOC acknowledged the identified gaps in the IPAC audits of the home.

There may have been an increased risk of transmission of infection as the home was not completing audits of their IPAC program in the home.

Sources: home's COVID-19 self assessment audits, COVID-19 Guidance Document for Long Term Care Homes in Ontario; interview with ADOC. [748]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to resident #002 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
O. Reg. 246/22, s. 57 (1) (2) required the home to have a pain management program that provided strategies to manage pain.

Resident #002 had a physician order for a PRN medication to help manage pain.

As per the administration records, there was no documentation that the resident received the medication for two months and only documented that the resident received it on three occasions in another month.

The resident stated that they had been receiving the medication. An RN stated that it was likely a documentation issue as the resident had been receiving the medication in the above timeframe.

Sources: Resident #002's clinical records; and interviews with resident #002, registered staff #133 and RN #134. [705243]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC#10 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that, for resident #005 and resident #006 demonstrating responsive behaviours, actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions.

Rationale and Summary
Residents #005 and #006 were found in an altercation. A clinical record review confirmed that both residents had a documented history of responsive behaviours.

A review of the residents' plans of care showed that both residents did not have a behaviour related focus, including goals and interventions.

A review of progress notes showed no evidence of a behavioural assessment completed for either resident, including identified triggers, strategies, and interventions.

An registered staff confirmed that behavioural assessments including triggers and interventions were to be documented using the 'behaviour/mood' progress note type and further confirmed that the residents did not have a documented behavioural assessment that included identified triggers, strategies and interventions developed and implemented to respond to these behaviours or actions taken to respond to the needs of the residents.

Both residents had known responsive behaviours prior to this incident. Both residents were injured at the time of the incident and both residents continued to demonstrate responsive behaviours, potentially putting other residents and staff at risk.

Sources: Resident #005 and resident #006's clinical records; CIS 2775-000019-22; and Interview with staff #116. [740884]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC#11 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 59 (a)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #005 and #006 and among other residents by failing to identify factors, based on an interdisciplinary assessment that could trigger a harmful interaction.

Rationale and Summary
Residents #005 and #006 were found in an altercation. A clinical record review confirmed that both residents had a documented history of verbal and physical responsive behaviours.

A review of care plans showed that both residents did not have a behaviour related focus, including goals and interventions.

Interviews with two separate registered staff confirmed that behavioural assessments including triggers and interventions were to be documented using the 'behaviour/mood' progress note type and that both residents did not have a documented behavioural assessment or documented interventions related to the responsive behaviors.

An interview with ADOC #101 confirmed that the residents were discussed in the homes daily responsive behaviour huddle after the altercation, however, further confirmed that neither resident's care plan was updated.

Both residents had known responsive behaviours prior to this incident. Both residents were injured at the time of the incident and both residents continued to demonstrate responsive behaviours, potentially putting other residents and staff at risk.

Sources: Resident #005's clinical record, resident #006's clinical record, CIS 2775-000019-22, Interview with staff #116, interview with staff #134, interview with staff #101. [740884]

WRITTEN NOTIFICATION: MENU PLANNING

NC#12 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 77 (6)

The licensee has failed to ensure that an individualized menu was developed for a resident, whose needs could not be met through the home's menu cycle.

Rationale and Summary
A resident had specific nutritional needs related to a health condition.

There were several complaints from the resident and family stating the food did not meet the resident's nutritional needs, they were not provided an individualized menu, were not aware of choices to eat, and the resident continued to be served inappropriate foods.

During separate interviews with staff, they stated that the home did not have an individualized menu for the resident, there were no standardized recipes or production sheets for the resident, and instead staff were provided a list of foods to restrict for the resident.

On occasion both dinner options made available to the resident were inappropriate for the resident's nutritional needs and the staff had to come up with alternative options.

By not providing the resident an individualized menu there was a risk of the resident consuming foods inappropriate to their nutritional needs, which may have impacted their quality of life with limited food choices.

Sources: Interviews with the resident, the RD, FSM and Cook #124; Policy No. 5.030A- Diet

Types and Textures; Policy No. 010000.22- Consulting Dietitian; resident #002's clinical record; Shalom Village SS 2022 Spring/summer Week 3 Sunday Therapeutic menu. [740882]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC#13 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 79 (1) 4

The licensee has failed to ensure that there was a process to ensure food service workers and other staff assisting residents were aware of a resident's diet, special needs and preferences.

Rationale and Summary
A resident had complained that they continued to be offered a specific food with limited alternative options although they had an allergy to that specific food.

There was a progress note that stated the resident had an allergy to that food however no mention of the allergy was included in the resident's care plan nor was there any documentation of informing the dietary staff of this allergy.

During an interview, the RD stated that they were made aware of the allergy but did not believe the allergy to be true as it was not stated during the resident's admission to the home. After the interview, the RD confirmed the allergy with the resident and their family during a care conference. The RD then updated the resident's care plan to state that consuming this food could cause anaphylactic shock. At time of inspection, the allergy was not updated in the allergies section of the home's documentation system, nor in the meal notes that staff follow during meal service.

Failing to ensure staff were made aware of the resident's diet and special needs in relation to their allergy placed the resident at potential risk of consuming an allergen food as well as negatively impacting the resident's quality of life by limiting their meal options.

Sources: Interview with the resident, the RD and FSM; and the resident's clinical records. [740882]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC#14 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 115 (1) (2)

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an unexpected death.

Rationale and Summary
A resident had a significant unexpected change of status requiring transfer to hospital. The resident subsequently passed away.

Interview with the DOC confirmed knowledge and awareness that the expectation is to immediately report an unexpected death to the Director. The DOC further confirmed that the incident was not reported into the Critical Incident Reporting system until two days later.

Sources: CIS Report from Critical Incident Reporting System; Interview with the DOC; Mandatory/Critical Incident Policy. [740884]

WRITTEN NOTIFICATION: EXCEPTIONS

NC#15 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 254 (3) (2) (iii)

The licensee has failed to ensure that before hiring or accepting a volunteer during a pandemic when a police record check was not provided, that subsection 252 (4) was applied with respect to any charge, order or conviction or other outcome, regardless of when they occurred.

Rationale and Summary
O. Reg. 246/22, s. 252 (4) stated that the licensee shall require the person provide the licensee, before the person is hired as a staff member or accepted as a volunteer, with a signed declaration disclosing the following:
1. All the following that occurred with respect to the person:
    i. Every charge for an offence prescribed under subsection 255(1) of O. Reg. 246/22 with which the person has been charged,
    ii. Every order of a judge or justice of the peace made against the person in respect of an offence prescribed under subsection 255(1), including a peace bond, probation order, prohibition order or warrant to arrest, and
    iii. Every conviction for an offence prescribed under subsection 255(1) or any other outcome of a charge for such an offence.
2. All the following that occurred with respect to the person:
    i. every commencement of a proceeding that could lead to a finding of guilt of an act of misconduct prescribed under subsection 255 (2), and
    ii. every finding of guilt of an act of misconduct prescribed under subsection 255 (2).

A review of staff hired by the licensee since May 30, 2022, revealed that before hiring 10 new staff members, the licensee did not require those individuals to provide the licensee with a signed declaration.

The Director of Human Resources (HR) identified that the home started receiving signed declarations from new staff members after July 21, 2022. They indicated that the 10 staff members had police record checks pending upon hire, between the dates of May 2022 and July 2022. They acknowledged that the home did not have a signed declaration for those 10 individuals before they were hired as a staff member (while their police record check was pending).

As a result of the non-compliance, there may have been an increased risk to residents' safety and security as the licensee was not able to rely on any signed declarations (and any information contained within) before hiring a person, to assist with determining their suitability to be a staff member in a long-term care home and to protect residents from abuse and neglect.

Sources: Review of the home's new hire list; signed declarations on file; and interview with the Director of HR. [748]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC#16 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee has failed to comply with CO #003 from inspection #2022_960695_0001 served on February 28, 2022, with a compliance due date of May 2, 2022.

Rationale and Summary
The home did not have 100% training completion of their policy to ensure that all staff, including new hires, are trained on the most current version of the LTCH's policy to promote zero tolerance of abuse and neglect of residents as required by the CO.

Sources: CO #003 from inspection #2022_960695_0001; the home's education records; interview with DOC. [748]

COMPLIANCE ORDER #001: DUTY TO PROTECT

NC#17 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 24 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 24 (1)

Specifically, the licensee must:

1. Provide re-education to registered staff #133 regarding what constitutes abuse and neglect, resident's rights, consent, and pain management. The home is to keep a record of all education provided, dates the education was provided, and the signature

of the registered staff member to verify they have received the education.

2. Ensure any allegations of abuse or neglect of resident #002 are immediately investigated and that appropriate actions are taken in response to the outcome of the investigations. Home to maintain documentation of investigation and actions taken.

3. Ensure any allegations of abuse or neglect for resident #002 are immediately reported to the Director.

4. The DOC and ADOC to review the home's policy on mandatory reporting. The home is to maintain a signed declaration from both the DOC and ADOC including what they reviewed and the date of the review.

Grounds

The licensee has failed to ensure that resident #002 was protected from neglect by registered staff #133.

Rationale and Summary

As per O. Reg. 246/22, neglect is defined as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

Resident #002 and their family members reported that the resident was often being denied ordered pain medications by registered staff #133. The home did not complete an investigation into the allegations or report the allegations to the Director.

The resident had two PRN physician orders to help manage pain. One of the medications was able to be administered two times a day as needed and the other was able to be administered six times a day as needed.

The registered staff documented that the resident was demanding the medication that was able to be administered six times a day as needed but documented that the resident was unable to receive it as they were only able to receive it at two specific times of the day. The registered staff member also documented that they were in disagreement with the resident demanding things on their terms regardless of the consequences. The resident was not documented to have received either of the available pain medications on that date.

The resident informed the inspector that they were not provided the medication on a specific occasion and that they had informed staff their pain was at a level nine out of ten. Failing to provide the medication as ordered and requested, jeopardized the resident's health and well-being.

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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Sources: Resident #002's clinical records; and interviews with registered staff #133, resident #002 and other staff. [705243]

This order must be complied with by December 1, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- 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
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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.