Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: August 8, 2024	
Inspection Number: 2024-1069-0003	
Inspection Type: Critical Incident	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Springdale Country Manor, Peterborough	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 12, 15, 16, 17, 18, 22, 23, 24, 2024. The inspection occurred offsite on the following date(s): April 19, 25, 26, 2024 and May 15, 16, 23, 24, 2024.

The following intake(s) were inspected:
Intake: #00114101 - Critical Incident (CI) - related to loss of essential services.

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

Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Reporting and Complaints

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. 115 (3) 2. iii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
iii. a loss of essential services, or

The licensee failed to ensure that the Director was informed within one business day after the occurrence of an environmental hazard, specifically related to a loss of essential services.

Rationale and Summary

A Critical Incident (CI), specifically a loss of essential services occurred.

The Administrator confirmed that the loss of essential services had not been reported as required by legislation.

Failure to notify the Director of an environmental hazard potentially delays information sharing and crucial updates regarding a Critical Incident, which in turn poses potential harm to residents residing in the long-term care home.

Sources: Review of the Critical Incident System; and an interview with the Administrator.

Date Remedy Implemented: April 17, 2024

WRITTEN NOTIFICATION: Emergency Plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (10) (a)
Emergency plans
s. 268 (10) The licensee shall,
(a) on an annual basis test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies, violent outbursts, gas leaks, natural disasters, extreme weather events, boil water advisories, outbreaks of a communicable disease, outbreaks of a disease of public health significance, epidemics, pandemics and floods, including the arrangements with the entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the Connecting Care Act, 2019, partner facilities and resources that will be involved in responding to the emergency;

The licensee failed to ensure emergency plans, specifically the plan related to loss

of essential services was tested on an annual basis..

Rationale and Summary

A Critical Incident related to a loss of essential services occurred at the long-term care home.

The licensee's emergency plans, and a document identified as 'Emergency Preparedness Completed Hazard and Drills Monthly Report' were reviewed.

Registered and non-registered nursing staff indicated being unfamiliar with their roles and responsibilities during a loss of essential service; the PSW, RPNs, and the RN indicated they did not recall emergency plans, which would include loss of essential services, being tested in 2023. The Maintenance Manager and the Director of Care (DOC) confirmed that loss of essential services was a component of the licensee's emergency plans; the Maintenance Manager and the DOC indicated loss of essential services was not tested in 2023.

The Administrator confirmed that loss of essential services, as part of the licensee's emergency plans, was not tested in 2023.

Failure of the licensee to ensure Emergency Plans, specifically loss of essential power, were tested on an annual basis poses gaps in care and services provided to residents, and ultimately poses risk of harm to residents when staff are not familiar with their role in an emergency.

Sources: Observations; review of 'Emergency Preparedness Completed Hazard Drills Monthly Report; and interviews with registered and non-registered nursing staff, Maintenance Manager, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Emergency Plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. ii.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
ii. fires,

1.The licensee failed to ensure that emergency plans were in place, specifically related to 'fires' and that such were complied with.

Pursuant to FLTCA, 2021, s. 90 (1), Every licensee of a long-term care home shall ensure there are emergency plans in place for the home that comply with the regulations, specifically measures for dealing with, responding to, and preparing for emergencies.

Pursuant to O. Reg. 246/22 s. 11 (1), Where the Act or Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, strategy, initiative or system, the licensee is required to ensure the plan, policy, protocol, program, procedure, strategy, initiative, or system.

Rationale and Summary

While conducting a Proactive Compliance Inspection, a Critical Incident (CI) related to the loss of essential services occurred and affected services at the long-term

care home. The loss of essential services affected an entry door, a designated emergency entrance, which in turn prompted further inspection of the licensee's emergency plans.

The licensee's emergency plans were reviewed. Documentation identified the licensee's Fire Prevention and Safety Plan was last approved by the Chief Fire Official in 2015. Documentation further identified OMNI Quality Living-Springdale Country Manor had been issued violations under the Ontario Fire Code. The violations had been issued by the Chief Fire Official earlier this year. Documentation referenced an Ontario Fire Code Violation and Notification report and a contracted service providers report. The contracted service providers report identified fire systems and equipment deficiencies at the LTCH. The document indicated that the violations posed significant risk to the safety of the occupants and the property.

The Chief Fire Official confirmed that the licensee, OMNI Quality Living-Springdale Country Manor, had been issued orders, for violations under the Ontario Fire Code, and further indicated the licensee had been identified as being in a state of 'chronic non-compliance' for several years; and indicated the non-compliances were related to the licensee's 'failure to follow their safety plan' and 'failure to ensure fire safety equipment or systems were in proper working order'.

Failure to ensure the licensee complied with their emergency plans, specifically related to fire safety and prevention posed serious risk of harm to residents and others.

At the time of the inspection, Springdale Country Manor, an OMNI Quality Living long-term care home, had existing orders in place under the Ontario Fire Code for violations, specifically related to 'failure to follow the licensee's fire safety plan' and 'failure to ensure fire equipment and supplies were in working order'.

Sources: Observations; review of the licensee's emergency plans, Ontario Fire Code Violation Notice and Inspection Order, contracted service provider report; and interviews with the management staff, OMNI Quality Living representative, and the fire department.

2.The licensee failed to ensure that emergency plans are in place, specifically related to 'fires' and that such are complied with.

Pursuant to FLTCA, 2021, s. 90 (1), Every licensee of a long-term care home shall ensure there are emergency plans in place for the home that comply with the regulations, specifically measures for dealing with, responding to, and preparing for emergencies.

Pursuant to O. Reg. 246/22 s. 11 (1), Where the Act or Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, strategy, initiative or system, the licensee is required to ensure the plan, policy, protocol, program, procedure, strategy, initiative, or system.

Rationale and Summary

While conducting a Proactive Compliance Inspection, a Critical Incident (CI) related to the loss of essential services occurred and affected services at the long-term care home. The CI affected an entry door, a designated emergency entrance, which in turn prompted further inspection of the licensee's emergency plans.

During the inspection, the licensee's emergency plans were reviewed. Documentation identified that the licensee OMNI Quality Living-Springdale Country Manor had been issued several violations under the Ontario Fire Code in 2024, and

that the violations were related to, 'failure of the licensee to follow their fire safety plan', and 'failure of the licensee to ensure fire equipment and supplies were in working order'. Documentation identified a contracted service provider for the licensee, had identified deficiencies with their inspection, which included deficiencies with fire systems and equipment within the home. Documentation identified the licensee had not taken actions to resolve the said deficiencies for an identified time period following the date of the report. Documentation identified the licensee was ordered, by the Chief Fire Official', to implement a '24/7 Fire Watch' due to the licensee's non-compliance with the Ontario Fire Code. Documentation identified that '24/7 Fire Watch' was ordered to be in place as of an identified date.

The Chief Fire Official confirmed the licensee was ordered to immediately implement the '24/7 Fire Watch' as part of their Fire Safety Plan and confirmed the '24/7 Fire Watch' was to be in effect as of an identified date. The Chief Fire Official indicated the Fire Watch was ordered due to concerns with the safety and well-being of residents residing at the long-term care home, resulting from the licensee's continued non-compliance with their Fire Safety Plan, and concerns that the fire safety equipment and systems in the home were not in working order. A local fire department designate indicated that the only person with the authority to stop a 'Fire Watch' is the 'Chief Fire Official'.

The Administrator confirmed that the '24/7 Fire Watch' was ordered by the Chief Fire Official on an identified date. The Administrator indicated they were advised, by phone, to stop the 24/7 Fire Watch approximately a week later, indicating that the direction came from a representative of OMNI Quality Living. The Administrator confirmed they had not been advised by the Chief Fire Official to stop the 24/7 Fire Watch.

A fire department representative confirmed the '24/7 Fire Watch had been

removed by the licensee, without providing the required documentation of the repairs.' The local fire department representative indicated the '24/7 Fire Watch' was re-instated by the Chief Fire Official, after it was found that the licensee had arbitrarily removed the Fire Watch without authorization of Chief Fire Official.

Failure of the licensee to comply with their emergency plans, specifically related to fire safety and prevention, and order issued under the Ontario Fire Code posed serious risk of harm residents and others at the long-term care home.

At the time of the inspection, Springdale Country Manor, an OMNI Quality Living long-term care home, had existing orders in place under the Ontario Fire Code for violations, specifically related to 'failure to follow the licensee's fire safety plan' and 'failure to ensure fire equipment and supplies were in working order'.

Sources: Observations; review of the licensee's emergency plans, Ontario Fire Code Violation Notice and Inspection Order, and a contracted service providers report; and interviews with the Administrator, and representatives of the fire department.

3.The licensee failed to ensure that emergency plans are in place, specifically related to 'fires' and that such are complied with.

Pursuant to FLTCA, 2021, s. 90 (1), Every licensee of a long-term care home shall ensure there are emergency plans in place for the home that comply with the regulations, specifically measures for dealing with, responding to, and preparing for emergencies.

Pursuant to O. Reg. 246/22 s. 11 (1), Where the Act or Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, strategy, initiative or system, the licensee is required to ensure the plan, policy,

protocol, program, procedure, strategy, initiative, or system.

Rationale and Summary

While conducting a Proactive Compliance Inspection, a Critical Incident (CI) related to the loss of essential services occurred and affected services at the long-term care home. The CI affected an entry door, a designated emergency entrance, which in turn prompted further inspection of the licensee's emergency plans.

The licensee's emergency plans were reviewed. Documentation identified that the long-term care home had been issued violations under the Ontario Fire Code, related to the licensee's 'failure to follow their fire safety plan', and 'failure to ensure fire equipment and supplies were in working order'. Documentation identified the licensee was ordered to immediately implement a '24/7 Fire Watch'. Documentation failed to provide evidence that the '24/7 Fire Watch' as ordered by the Chief Fire Official, had been consistently complied with as directed during the identified period.

The Chief Fire Official confirmed the licensee, OMNI Quality Living-Springdale Country Manor, was ordered to immediately initiate a '24/7 Fire Watch' on an identified date and indicated the '24/7 Fire Watch' was to be in place until the licensee was compliant with the approved Fire Safety Plan.

The Administrator confirmed 'there were omissions in documentation related to the 24/7 Fire Watch'.

Failure of the licensee to comply with their emergency plans, specifically related to fire safety and prevention, and an order issued under the Ontario Fire Code posed serious risk of harm and or death to residents and others at the long-term care

home.

At the time of the inspection, Springdale Country Manor, an OMNI Quality Living long-term care home, had existing orders in place under the Ontario Fire Code for violations, specifically related to 'failure to follow the licensee's fire safety plan' and 'failure to ensure fire equipment and supplies were in working order'.

Sources: Observations; review of the licensee's emergency plans, Ontario Fire Code Violation Notice and Inspection Order, and 24/7 Fire Watch records; and interviews with the Administrator, and fire department designates.

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

1.The licensee failed to ensure that persons who had received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, related to emergency procedures.

Pursuant to O. Reg. 246/22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

A Critical Incident (CI) related to a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated they did not recall receiving annual retraining related to emergency procedures, specifically loss of essential services. The PSW, RPN, and the RN indicated being unfamiliar with their roles and responsibilities during a loss of essential services.

Staff training records for 2023, specifically related to emergency procedures: loss of essential services, were reviewed. Documentation identified the following:

- Code Grey – 15.7 % had not completed training in 2023.

The Director of Care, and the Administrator, who is the Lead for Education, confirmed staff training related to emergency plan, specifically 'loss of essential services' was incomplete in 2023. The DOC and the Administrator indicated that such was to be completed annually by all staff.

The following non-compliance were identified within this report related to staff training:
Compliance Order (CO) - Pursuant to, O. Reg. 246/22, s. 268 (14) (b) - Every licensee of a long-term care home shall ensure that staff, volunteers, and students are trained on the emergency plans, at least annually.

Failure to ensure staff were provided annual retraining related to emergency plans, specifically 'loss of essential services' poses gaps in resident care and services, which poses risk to residents in an emergency. Failure to ensure staff are trained in their roles and responsibilities negates their accountability.

Sources: Observations; review of the licensee's 2023 staff training stats related to emergency plans; and interviews with registered and non-registered nursing staff, Director of Care, and the Administrator.

2.The licensee failed to ensure that persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, related to fire prevention and safety; and emergency and evacuation procedures.

Pursuant to O. Reg. 246/22, s. 260 (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Rationale and Summary

A Critical Incident (CI) related to a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated they did not recall annual retraining related to emergency preparedness occurring.

Staff training records for 2023, specifically related to emergency procedures were reviewed. Documentation identified the following:

-Code Red, fire prevention and safety – 42.9 % had not completed training
-Code Brown, hazardous spill – 19.4 % had not completed training
-Code Orange, external disaster – 15.7 % had not completed training
-Code Green, evacuation – 15.7 % had not completed training

The Director of Care, and the Administrator, who is the Lead for Education, confirmed staff training related to emergency plans was incomplete in 2023. The DOC and the Administrator indicated that such was to be completed annually by all staff.

The following non-compliance were identified within this report related to staff training:
Compliance Order (CO) - Pursuant to, O. Reg. 246/22, s. 268 (14) (b) - Every licensee of a long-term care home shall ensure that staff, volunteers, and students are trained on the emergency plans, at least annually.

Failure to ensure staff were provided annual retraining related to fire prevention and safety, and emergency plans posed gaps in care and services, which poses risk of harm to residents and others during an emergency. Failure to ensure staff were trained in their roles and responsibilities negates their accountability, especially during an emergency.

Sources: Review of the 2023 staff training stats related to fire prevention and safety, and emergency plans; and interviews with registered and non-registered nursing staff, Director of Care and the Administrator.

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (d)
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,
(d) addressing incidents of lingering offensive odours.

The licensee failed to implement procedures to address incidents of lingering and offensive odours in the long-term care home.

Rationale and Summary

A Proactive Compliance Inspection (PCI) and Critical Incident Inspection were completed concurrently.

Throughout PCI and CI inspections, the Inspector detected a lingering and offensive odour in the long-term care home. The odour was noticeable upon entry to the long-term care home and as one walked about the home; the odour grew increasingly apparent as within identified residential hallways and resident rooms.

The licensee's policy, 'Management of Lingering Offensive Odours' indicated that lingering offensive odours will be managed. The policy indicated additional cleaning will be deemed necessary by the registered nursing staff and/or the Environmental Services Manager (ESM). The environmental services staff will communicate any lingering offensive odours to nursing staff and/or the ESM that remain after a room clean; the ESM will immediately respond and check the room(s) reported to have a lingering offensive odour to determine the cause and the area(s) of the room holding the odour. Based on the assessment, the ESM or designated will determine and implement interventions in addition to daily cleaning, which will include determining if flooring, baseboard, toilet, ect. may be harbouring or causing the odour and require replacement.

An Environmental Service Aid (ESA) indicated the lingering and offensive odour was 'urine' and that the odour was emanating from an identified resident room. The ESA indicated the room is cleaned daily by environmental services, but indicated the resident was known to exhibited identified responsive behaviours. The ESA indicated nursing staff and managers, as well as the Environmental Services Manager (ESM) were aware of the resident's exhibited behaviours.

The ESM and the Administrator indicated being unable to smell the offensive and lingering odour.

Failure to implement interventions to reduce or eliminate the cause of lingering and offensive odours is unsanitary. Odours in the home are unpleasant to those residing at the home, as well as for those visiting.

Sources: Observations; review of the licensee's policy 'Management of Lingering Offensive Odours'; and interviews with an ESA, Environmental Services Manager, and the Administrator.

WRITTEN NOTIFICATION: Emergency Plans

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (5)
Emergency plans
s. 268 (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation, including identifying who or which entity declares there is an emergency at the home and who or which entity declares that the emergency is over at the home, as agreed upon by the entities the licensee consulted with under clause (3) (a).

2. Lines of authority.
3. A communication plan.
4. Specific staff roles and responsibilities.

The licensee failed to ensure their emergency plans, specifically loss of essential services, addressed the plan of activation, a communication plan and specific staff roles and responsibilities.

Rationale and Summary

A Critical Incident (CI), related to the loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated being unclear of their roles and responsibilities during the CI. At the time of the CI, the Administrator and leadership team were onsite and directing staff.

The licensee's emergency plans, specifically the 'Infrastructure Loss/Failure' policy was reviewed. The document failed to identify the plan of activation, lines of communication and specific roles and responsibilities of staff.

The Administrator confirmed the policy did not include information for staff to follow, specifically related to their roles and responsibilities during the emergency situation.

Failure of the emergency plans, specifically 'loss of essential services' to provide direction as to the plans of activation, lines of communication, and specific staff roles and responsibilities poses gaps in resident care and services, and poses potential risk of harm to residents.

Sources; Observations; review of the licensee's emergency plans, specifically 'Infrastructure Failure/Loss'; and interviews with registered and non-registered nursing staff, Environmental Services Manager, and the Administrator.

WRITTEN NOTIFICATION: Emergency Plans

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (10) (d)
Emergency plans
s. 268 (10) The licensee shall,
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

1.The licensee failed to ensure the testing of the emergency plans were recorded.

Rationale and Summary

A Critical Incident (CI) related to a loss of essential services occurred at the long-term care home.

The licensee's emergency plans, and a document identified as 'Emergency Preparedness Completed Hazard and Drills Monthly Report' were reviewed. Documentation indicated that fire drills had been completed at the long-term care home in February 2023. Documentation failed to identify records of staff participation in the said fire drills.

The Administrator confirmed that 'fire drills' were a component of the licensee's

emergency plans, specifically related to fire prevention and safety. The Administrator was unable to provide any documentation related to the fire drills, indicating they do not record staff attendance, as part of testing of the emergency plans.

Failure to ensure testing of the emergency plans were recorded prevents the licensee from knowing which staff participated in the testing of the plan, and negates staff accountability, in their roles and responsibilities, especially as such relates to an emergency, which in turn poses risk of harm to residents.

Sources: Review of 'Emergency Preparedness Hazard and Drills Monthly Report; and an interview with the Administrator.

2.The licensee failed to ensure the testing of the emergency plans were recorded.

Rationale and Summary

A Critical Incident (CI) related to a loss of essential services occurred at the long-term care home.

The licensee's emergency plans, and a document identified as 'Emergency Preparedness Completed Hazard and Drills Monthly Report' were reviewed.

The Maintenance Manager and the Director of Care indicated no recall of the said emergency plan being tested or discussed in 2023.

The Administrator could not provide written records to indicate the date the Code Grey, as an emergency plan, was last tested.

Failure to ensure testing of the emergency plans were recorded prevents the licensee from knowing which staff participated in the testing of the plan, and negates staff accountability, in their roles and responsibilities, especially as such relates to an emergency, which in turn poses gaps in care and services and poses risk of harm to residents.

Sources: Review of 'Emergency Preparedness Hazard and Drills Monthly Report; and an interview with Maintenance Manager, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Emergency Plans

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (11)
Emergency plans
s. 268 (11) If there is a conflict or an inconsistency between a provision of the fire code under the Fire Protection and Prevention Act, 1997 and a provision of an emergency plan, the fire code prevails to the extent of the conflict or inconsistency.

The licensee failed to ensure if there was a conflict or an inconsistency between a provision of the fire code and a provision of an emergency plan, the fire code would prevail.

Rationale and Summary

A Critical Incident (CI) related to the loss of essential services, occurred in the long-term care home.

The licensee's emergency preparedness plans were reviewed. Documentation identified the 'Fire Safety Plan for Springdale Country Manor' was last signed in 2015, by Administrator, of the long-term care home and the Chief Fire Official.

The Environmental Services Manager and the Administrator confirmed the 'Fire Safety Plan' letter dated in 2015 was the most recent signed letter on file. The Administrator indicated the 'Fire Safety Plan' document had not been updated or signed by the Chief Fire Official, for the township.

The Chief Fire Official indicated the long-term care home did have an enforced and approved Fire Safety Plan, but they had not signed 'off' on the licensee's Fire Safety Plan, as the plan contained information irrelevant to fire. The Chief Fire Official indicated the Fire Safety Plan should only contain information relevant to the Ontario Fire Code, and indicated the licensee was directed to review their Fire Safety Plan and resubmit.

At the time of the inspection, Springdale Country Manor, an OMNI Quality Living long-term care home, had existing orders in place under the Ontario Fire Code for violations, specifically related to 'failure to follow the licensee's fire safety plan' and 'failure to ensure fire equipment and supplies were in working order'. The Chief Fire Official indicated to the best of their knowledge all fire equipment and systems were in working order, at the home.

Failure of the licensee to ensure the Fire Code prevails in the event of a conflict or inconsistency with the legislation dilutes the importance of the Ontario Fire Code, especially at such relates to a vulnerable sector occupancy. Failure to ensure the licensee's 'Fire Safety Plan' contains only information relevant to 'fire' poses risk of staff and managers understanding their roles and responsibilities in the event of an

emergency.

Sources: Review of the licensee's emergency preparedness manual, 'Fire Safety Plan' letter dated 2015; and interviews with Environmental Services, Manager, Administrator and fire department designates.

WRITTEN NOTIFICATION: Attestation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (1) (e)
Attestation
s. 270 (1) Every licensee of a long-term care home shall prepare an attestation as required by section 90 of the Act in a form approved by the Minister which includes,
(e) a statement attesting that the requirements in section 90 of the Act and sections 268 and 269 of this Regulation have been complied with;

The licensee failed to ensure that requirements in section 90 of the Act, and sections 268 and 269 of the regulations had been complied with.

Pursuant to FLTCA, s. 90 (2), Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated, and reviewed with the staff of the home as provided for in the regulations.

Pursuant to O. Reg. 246/22, s. 268 (10) (a), The licensee shall on an annual basis test the emergency plans related to, but not limited to, the loss of essential services.

Pursuant to O. Reg. 246/22, s. 268 (14) (b) Every licensee of a long-term care home shall ensure that staff, volunteers, and students are trained on the emergency plans,

at least annually.

Rationale and Summary

A Critical Incident, specifically a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated being unfamiliar with their roles and responsibilities during the CI. The PSW, RPN, RN, Maintenance Manager, and the Director of Care indicated having no recall of the licensee's emergency plans, specifically loss of essential services, being tested and/or evaluated in 2023. The Director of Care indicated that all staff had not received training in 2023 surrounding the licensee's emergency plans.

The licensee's 'Emergency Planning Attestation' form which was submitted to the Director was reviewed. The document indicated that all requirements in accordance with section 90 of the Act, and sections 268 and 269 of the Regulation have been complied with. The document had been signed by the Administrator on an identified date in 2023.

The Administrator confirmed signage of the 'Emergency Planning Attestation' and submission to the Director. The Administrator indicated being aware that the emergency plans, specifically, loss of essential services had not been tested or evaluated in 2023, and further indicated they were aware all staff were not provided training related to emergency plans in 2023.

Failure to ensure emergency plans had been tested and evaluated, and that staff had been provided training regarding emergency plans posed gaps in the care and services afforded to residents, negates staff accountability in their roles and

responsibilities during emergency situations, and ultimately places residents at risk of harm.

Sources: Review of 'Emergency Preparedness Completed Hazard Drills Monthly Report, Emergency Planning Attestation form submitted to the Director [December 20, 2023]; and interviews with registered and non-registered nursing staff, Maintenance Manager, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Attestation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (1) (f)
Attestation
s. 270 (1) Every licensee of a long-term care home shall prepare an attestation as required by section 90 of the Act in a form approved by the Minister which includes,
(f) a statement attesting that all of the information and answers provided in the attestation are complete, true, and correct; and

The licensee failed to ensure their 2023 Emergency Planning Attestation statement was true and correct.

Rationale and Summary

A Critical Incident, specifically a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated being unfamiliar with their roles and responsibilities during the CI. The PSW, RPN, RN, Maintenance Manager,

and the Director of Care indicated having no recall of the licensee's emergency plans, specifically loss of essential services, being tested and/or evaluated in 2023. The Director of Care indicated that all staff had not received training related to emergency plans in 2023.

The licensee's 'Emergency Planning Attestation' form which was submitted to the Director was reviewed. The document indicated that all requirements in accordance with section 90 of the Act, and sections 268 and 269 of the Regulation have been complied with. The document indicated that the information and answers provided in the attestation were complete, true, and correct. The 'Emergency Planning Attestation' form was signed by the Administrator in 2023.

The Administrator confirmed they completed and submitted the 'Emergency Planning Attestation' form. The Administrator indicated being aware that the emergency plans, specifically, loss of essential services had not been tested or evaluated in 2023, and further indicated being aware that all staff were not provided training related to emergency plans in 2023.

Failure to ensure the 2023 'Emergency Planning Attestation' was true and correct discredits the integrity of the licensee and/or their designate, posed concerns related to transparency and disclosure of accurate information to the Director, posed gaps in the care and services afforded to residents and ultimately places residents at risk of harm.

Sources: Review of 'Emergency Preparedness Completed Hazard Drills Monthly Report, Emergency Planning Attestation form submitted to the Director; and interviews with registered and non-registered nursing staff, Maintenance Manager, Director of Care, and the Administrator.

WRITTEN NOTIFICATION: Attestation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (1) (g)
Attestation
s. 270 (1) Every licensee of a long-term care home shall prepare an attestation as required by section 90 of the Act in a form approved by the Minister which includes,
(g) a statement attesting that the licensee understands that any misrepresentation, falsification, or omission of any material facts in the attestation may render the attestation void.

The licensee failed to ensure they did not misrepresent, or falsify material facts in the 2023 Emergency Planning Attestation statement submitted to the Director, which in turn renders the attestation void.

Rationale and Summary

A Critical Incident, specifically a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff, Maintenance Manager, and the Director of Care indicated having no recall of the licensee's emergency plans, specifically loss of essential services, being tested and/or evaluated in 2023. The Director of Care indicated that all staff had not received training related to emergency plans in 2023.

The licensee's 'Emergency Planning Attestation' form which was submitted to the Director was reviewed. The document indicated that all requirements in accordance

with section 90 of the Act, and sections 268 and 269 of the Regulation have been complied with. The document indicated that the information and answers provided in the attestation were complete, true, and correct; and indicated the signee and the licensee understood that any misrepresentation, falsification, or omission of any material facts in the attestation may render the attestation void. The 'Emergency Planning Attestation' form was signed by the Administrator.

The Administrator confirmed they completed and submitted the 'Emergency Planning Attestation' form. The Administrator indicated being aware that the emergency plans, specifically, loss of essential services had not been tested or evaluated in 2023, and further indicated being aware that all staff had been provided training in 2023 related to emergency plans.

Failure to ensure the 2023 'Emergency Planning Attestation' was true and correct discredits the integrity of the licensee and/or their designate, poses concerns with transparency and disclosure of information to the Director, posed gaps in the care and services afforded to residents, and ultimately places residents at risk of harm. Misrepresentation and falsification of materials facts in the attestation renders the attestation void.

Sources: Review of 'Emergency Preparedness Completed Hazard Drills Monthly Report, Emergency Planning Attestation form submitted to the Director; and interviews with registered and non-registered nursing staff, Maintenance Manager, Director of Care, and the Administrator.

COMPLIANCE ORDER CO #001 Accommodation services

NC #012 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.

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

1.OMNI Quality Living, in collaboration with the Maintenance Manager, Administrator, and a contracted service provider will assess and ensure the identified door of the long-term care home, which is considered an emergency exit, is able to fully function during loss of power. Documentation of this assessment and any needed repair will be kept and made immediately available to the Inspector upon request.

2.OMNI Quality Living, in collaboration with the Maintenance Manager and the Administrator, will have the flooring-concrete in the identified vestibule within the long-term care home, which is considered an emergency exit, repaired and/or replaced. The Maintenance Manager, in collaboration with the Administrator and OMNI Quality Living, will ensure all emergency exits are in a good state of repair, and if identified not to be in a good state of repair corrective action is to be taken.

3.OMNI Quality Living, in collaboration with the Maintenance Manager and the Administrator, are to have the generator's fuel tank inspected by a licensed inspector and if needed replaced. Documentation of the fuel tank inspection and or its replacement is to be kept and made available to the Inspector upon request.

4.The Environmental Services Manager, in collaboration with the Maintenance

Manager and the Administrator, will develop and implement a plan to ensure that all staff are aware of the area of sunken flooring in the identified dining room and that the area is at all times covered, ensuring that such decreases or eliminates a fall-trip hazard. The development, implementation of the plan, and all communication to staff must be recorded. Documentation must be kept and made available to the inspector upon request.

5.The Maintenance Manager is to repair or replace the baseboard heater/rad cover in an identified resident room, and the identified communal washroom; secure the window screens in the identified dining room, an identified lounge and identified resident room; and reassess the need for electrical cords in an identified resident room, if the cords are required, the Maintenance Manager will ensure the cords are not posing a trip-fall hazards.

Grounds

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

Rationale and Summary

A Critical Incident (CI) related to loss of essential services occurred at the long-term care home. The CI affected services afforded to residents residing at the long-term care home. The CI was inspected concurrently with a Proactive Compliance Inspection.

An identified entry/exit door of the long-term care home, which is also considered an emergency exit, was not functioning.

The Maintenance Manager and the Administrator indicated that the identified door

in the home was not able to operate during the Critical Incident, and confirmed the door was considered an emergency exit. The Maintenance Manager indicated that the door was not connected to the onsite generator, as the generator did not have the ability to operate the door due to the generator's age and limited capacity. The Maintenance Manager indicated the concern regarding the entry door not being connected to the generator, and the doors inability to operate during an emergency, had been previously communicated to the licensee.

Failure of the licensee to maintain the home and its equipment in a safe condition and in a good state of repair posed risk to the safety of residents, families, visitors, and staff, especially in relation to an emergency.

Sources: Observations; review of contracted service provider invoices, testing and inspection reports; and interviews with contracted service providers, the Environmental Services Manager, Maintenance Manager, Administrator and the licensee.

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

Rationale and Summary

A Critical Incident (CI) related to loss of essential services occurred at the long-term care home.

During the CI inspection, families were observed being directed by registered nursing staff, and the Administrator, to enter and exit through a side door of the long-term care home, as the main entry door was inoperable. Families and a

resident were observed entering and exiting the long-term care home via an alternate entry, into a vestibule, through a second door and into a residential hallway. The doors and the vestibule were identified as 'emergency exits'. The tiled flooring and the underlying concrete floor in the vestibule were observed to be cracked and having areas with loose concrete. The area of disrepair spanned the entire width of the vestibule.

The Maintenance Manager and the Administrator indicated being unaware that the vestibule was in a state of disrepair. The Maintenance Manager indicated that the cracked flooring and loose areas of concrete were a trip-fall hazard.

Failure of the licensee to maintain flooring in a vestibule within an emergency exit poses risk of harm to residents, families, staff, and others.

Sources: Observations; and interviews with Maintenance Manager, and the Administrator.

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

Rationale and Summary

A Critical Incident (CI) related to loss of essential services occurred at the long-term care home.

It was identified during the inspection that the generator's fuel tank was running low on fuel and could not be refueled.

The Maintenance Manager and the Administrator indicated that a contracted service

provider had refused to refuel the generator's fuel tank. The Maintenance Manager indicated that the service provider had refused to refuel the fuel tank as the tank needed to be inspected prior to refueling. The Maintenance Manager indicated that the fuel tank was 'old and in need of replacement and would not pass an inspection' to allow for refueling. The Maintenance Manager indicated OMNI Quality Living, the licensee for the long-term care home, was aware that the generator's fuel tank needed to be replaced.

Failure of the licensee to maintain the home and its equipment in a safe condition and in a good state of repair posed risk to the safety, comfort and well-being of residents residing at the long-term care home.

Sources: Observations; review of service provider fuel invoice record, and contracted service providers invoices, testing and inspection reports; and interviews with contracted service providers, the Environmental Services Manager, Maintenance Manager, Administrator and the licensee.

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed concurrently with the Critical Incident (CI) Inspection. During the inspection, an initial tour of the long-term care home was completed, and the following was observed:

-the baseboard heater's cover was observed laying on the floor in an identified resident room. The metal baseboard heater's covers observed, were rusted and jagged in nature.

-the baseboard heater's cover was observed half off in a communal resident washroom. The metal baseboard heater covers observed, were rusted and jagged in nature.
-electrical cords were observed strung across the floor in an identified resident room; this is a shared resident room.
-screens, on 3 windows in an identified dining room, a window in a resident lounge, and an identified resident room were loosely fitting.

The Environmental Services Manager (ESM) indicated that any areas within the home and or equipment identified by staff as needing repair are to be written in the 'Maintenance Log' binder. The ESM indicated the Maintenance Manager reviews the Maintenance Log and would sign off when repairs are completed. The ESM indicated it is an expectation that staff communicate any repairs needed so that corrective action can be taken by environmental services.

The Maintenance Log binder was reviewed. Documentation failed to identify that the baseboard heaters and the loosely fitting screens were identified as needing repair.

Failure of the license to ensure the home was maintained in a safe condition and a good state of repair posed risk of harm to residents.

Sources: Observations; and an interview with the Environmental Services Manager.

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

Rationale and Summary

A Proactive Compliance Inspection (PCI) was completed concurrently with the Critical Incident (CI) inspection. During the inspection, an initial tour and a meal observation were completed and the following observed:

-the tiled flooring in an identified dining room was observed visibly sunken.

The Environmental Services Manager (ESM) indicated awareness of the sunken flooring in the dining room and indicated the area had been identified as a 'trip-fall hazard' years ago. The ESM indicated the identified area was to be covered with a dining room table to avoid risk to residents.

Failure of the license to ensure the home was maintained in a safe condition and a good state of repair, specifically dining room flooring, poses a trip-fall hazard ad places residents at risk of injury.

Sources: Observations; and an interview with the Environmental Services Manager.

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

Rationale and Summary

A Critical Incident (CI) related to loss of essential services. The CI affected services afforded to residents residing at the long-term care home.

While inspecting the CI, documentation was reviewed including the licensee's emergency plans, a contracted service providers report, and an order issued to the licensee under the Ontario Fire Code. Documentation identified that the fire safety equipment and systems had been deficient, and had been identified as being in a

state of disrepair without the licensee taking corrective action for an identified period.

The Chief Fire Official indicated the licensee, OMNI Quality Living-Springdale Country Manor's failure to maintain their fire equipment and its systems in working order contributed to an order being issued in 2024. The Chief Fire Official indicated the licensee had been 'in a state of chronic non-compliance', for various fire safety plan and equipment violations, including fire equipment and its systems several years. The Chief Fire Official indicated failure of the licensee to maintain their fire equipment and systems posed risk to the long-term care home, and that such had been brought to the attention of licensee and its designate, as well as to the Ontario Fire Marshall.

Failure of the licensee to ensure the long-term care home's fire equipment and systems are maintained in a safe condition and a good state of repair poses a serious risk of harm and/or death to residents and staff.

The Chief Fire Official indicated that to the best of their knowledge the fire equipment and systems at the long-term care home are now in working order.

Sources: Review of the licensee's emergency plans, specifically related to 'fire', a contracted service providers report, a Fire Code Order, Ontario Fire Marshall Directive Notification Requirements for Serious Fire Risk in Long-Term Care Issued under the Fire Protection and Prevention Act, correspondence between representatives of OMNI Quality Living-Springdale Country Manor, OMNI Quality Living-Director (the licensee) and fire department representatives.

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #002 Generators

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 22 (3)
Generators
s. 22 (3) The licensee of a home to which subsection (2) applies shall ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 246/22, s. 22 (3).

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

1.The licensee, OMNI Quality Living is to immediately ensure the onsite generator is 'fully' operational, and can power and maintain function to all requirements and equipment pursuant to O. Reg. 246/22, s. 22 (1), including but not limited to, the industrial refrigerator and steam table located on the west wall in the main kitchen, medication and vaccine refrigerators in the medication room and/or other medication storage locations, the front door/emergency exit, and all equipment used to prepare and deliver drugs.

2.The licensee, OMNI Quality Living must provide written documentation by a contracted service provider (e.g. electrician) that the onsite generator has the capacity to maintain all essential services and equipment required by the legislation. Documentation by the contracted service provider must include detailed verification that the generator has the capacity to maintain all essential services required, the document dated and signed and/or stamped by the contracted service provider who provided this verification. The document must be kept, on site at the property

identified as Springdale Country Manor, and must be made immediately available upon request by the Inspector.

3.The Administrator or their management designate must provide a written communication to all staff, outlining services and equipment the onsite generator has the capacity to power and maintain in the event of an emergency. Additionally, this communication is to be laminated, and posted in the medication room, in the main kitchen, maintenance room, and management offices for reference in the event of a power loss. The communication is to be shared with Resident and Family Councils. Documentation of this communication to staff, and Councils is to be kept and made immediately available upon request by the Inspector.

Grounds
The licensee failed to ensure that the long-term care home had access to a generator, that was operational and could maintain everything required by the legislation.

Pursuant to O. Reg. 246/22, s. 22 (1) (c), Every licensee of a long-term care home shall ensure the home is served by a generator that is available at all times and has the capacity to maintain in the event of a power outage, essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, equipment required to store drugs at safe temperatures and to prepare and deliver drugs, and life support, safety and emergency equipment.

Rationale and Summary

A Critical Incident, specifically a loss of essential services due to a power outage that occurred.

While inspecting the CI, it was identified that the onsite generator did not have the capacity to maintain all essential services, specifically the following equipment:
-an industrial sized refrigerator;
-a steam table;
-a medication refrigerator;
-a vaccine refrigerator;
-a entry/exit door, which is an designated emergency exit;
-computers which were utilized to prepare and deliver drugs to residents.

The Maintenance Manager, Director of Care and the Administrator indicated being aware that the generator, hard-wired to the long-term care home, did not have the capacity to maintain essential services as required by the legislation. The Maintenance Manager, Director of Care and the Administrator indicated their corporate office, OMNI Quality Living was aware that the generator did not have the capacity to service required essential services at the home.

The Director of Assets, for OMNI Quality Living indicated they were not aware the onsite generator did not have the capacity to service all essential services at the long-term care home,

A contracted service provider, indicated the generator was 'old' and did not have the capacity to operate on a full load, and therefore could not operate all essential services required in the event of a power outage. The Contracted Service Provider indicated the licensee, OMNI Quality Living, had been aware of the generator's capacity deficiencies since 2022.

Failure of the licensee to ensure the onsite generator had the capacity to maintain essential services poses gaps in the care and services afforded to the residents

residing at Springdale Country Manor, and in turn posed risk to the safety, comfort, and well-being of residents.

Sources: Observations; review of contracted service invoices for the generators repair and inspections; and interviews with registered and non-registered nursing staff, Maintenance Manager, Environmental Services Manager, Director of Care, Administrator, OMNI Quality Living-Director of Assets, Contracted Service Providers, and fire department designates.

This order must be complied with by October 31, 2024

COMPLIANCE ORDER CO #003 Emergency plans

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (14) (b)
Emergency plans
s. 268 (14) Every licensee of a long-term care home shall ensure that staff, volunteers and students are trained on the emergency plans,
(b) at least annually thereafter.

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

1.Train all staff, who were not trained in 2023, related to ALL emergency plans required under O. Reg. 246/22, s. 268 (4). The training is to be documented including, the date of the training, name of staff trained and their role, and the platform used to conduct the training. A record of the training is to be kept and made available to the Inspector upon request.

2. The Administrator, who is the designated Education Lead, is responsible to oversee the completion of the training.

3. This training is in addition to any training requirement(s) for 2024.

Grounds
The licensee failed to ensure all staff were trained on emergency plans annually, specifically provided training in 2023.

Rationale and Summary

A Critical Incident (CI) related to a loss of essential services occurred at the long-term care home.

Registered and non-registered nursing staff indicated being unfamiliar with their roles and responsibilities during the power outage. The PSW, RPNs, and the RN indicated they did not recall being provided training in 2023 related to emergency plans, including loss of essential services.

Staff training stats for 2023, related to emergency plans, were reviewed. Documentation failed to identify that all staff received training in 2023, related to emergency plans. Documentation further identified that the licensee had been previously issued a directive by the Chief Fire Official regarding staff training, specifically related to Fire Safety and Prevention, which is a component of emergency plans.

The Director of Care, and the Administrator, who is the Lead for Education, confirmed staff training related to emergency plans was incomplete in 2023. The

DOC and the Administrator confirmed awareness that all staff were to receive training annually.

The following non-compliance were identified within this report specific to the resident:
Written Notification (WN) - Pursuant to FLTCA, s. 82 (4) - Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Failure to ensure staff were provided annual retraining related to fire prevention and safety, and emergency plans posed gaps in resident care and services, which poses risk of harm to residents and others in an emergency. Failure to ensure staff were trained in their roles and responsibilities negates their accountability, especially during an emergency.

Sources: Observations; review of staff training stats for 2023, specifically related to 'emergency plans'; and interviews with registered and non-registered nursing staff, Director of Care, and the Administrator.

This order must be complied with by October 31, 2024

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

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.