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

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Original Public Report

Report Issue Date: July 24, 2024	
Inspection Number: 2024-1409-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Hope, Port Hope	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18-21, 24-27, 2024

The following intake(s) were inspected:
Intake: #00116918 - PCI - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the home has a dining and snack service that includes, at minimum, communication of the seven-day and daily menus to residents.

Rationale and Summary:
A proactive compliance inspection was conducted at the long-term care home and included observations of dining service. The following menu postings at the dining area on a resident home area was observed:
-Fall/Winter Menu: Week 1 November 13-19
-Fall/Winter Menu: Week 2 November 20-26
-Fall/Winter Menu: Week 3 November 27-December 3

Observations were made on another resident home area for the seven-day menu postings. The whiteboard at the end of the hallway did not have any menus posted, and the board by the servery had also the Fall/Winter Menus posted dated November and December.

The home's Dietary Manager indicated that they were responsible to post the seven-day menus on either the board by the servery or on the whiteboard by at the end of the hallway. They acknowledged that the seven-day menus were not posted for the current week. In follow-up observation, the seven-day menus were posted for the week.

Failure to communicate the seven-day menu to residents impact pleasurable mealtime and dining experiences.

Sources: observations, interview with Dietary Manager

Date Remedy Implemented: June 19, 2024

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure they sought the advice of the Residents' Council and the Family Council, if any, in carrying out the survey.

Rationale and Summary:
In an email correspondence to the Inspector, the Quality Risk Management Coordinator (QRMC) indicated that the home did not have meeting notes that indicated that the residents council reviewed the survey.

The Program Manager and QRMC both acknowledged that resident's council did not review the Resident and Family Experience survey and were not given the opportunity to advise the home and make suggestions prior to the Resident and Family Experience survey being carried out.

Failing to ensure residents and families participated in the Resident and Family Caregiver Experience Survey, provided a missed opportunity for the home to meet resident and family expectations.

Sources: Emailed correspondence, interviews with the Program Manager and QRMC.

WRITTEN NOTIFICATION: POWERS OF RESIDENTS' COUNCIL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond to the Residents' Council in writing within 10 days of receiving advice by the Residents' Council of concerns or recommendations.

Rationale and Summary:
The home had established a Residents' Food Committee. A review of the recent Food Committee meeting notes indicated that a number of concerns and/or recommendations were advised by the Food Committee.

There was no record of written responses attached to the Food Committee meeting notes relating to the advice by the Residents' Food Committee.

The Dietary Manager indicated that they were not aware of the requirement to provide a written response to the Residents' Food Committee within 10 days of receiving the advice and that it would be done going forward.

The licensee's policy entitled Resident Food Committee stated that a Resident Food Committee present in the home encourages residents to provide input on menu and delivery of meal service. The policy indicated response to be provided to all comments and issues identified during the meeting in writing within 10 business days of the meeting and were to document all actions taken to resolve the issues.

Failure to respond the Resident's Food Committee in writing within 10 days of receiving advice on concerns or recommendations impact the evaluation of organized meal service and affects pleasurable mealtime and dining experiences.

Sources: review of Resident Food Committee meeting notes, licensee's policy Resident Food Committee, interview with the Dietary Manager.

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.

The licensee has failed to ensure that a PSW received their Infection Prevention and Control (IPAC) annual retraining, as outlined under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Rationale and Summary:
As part of the home's proactive compliance inspection, Infection Prevention and Control (IPAC) Practices was reviewed. The Inspector requested a PSW's IPAC annual retraining from the DOC. Review of the PSW's annual training record, indicated their IPAC retraining was not signed off as being complete, for March 31, 2024.

In an interview, the IPAC lead agreed that the PSW's IPAC annual training was not complete and should have been. That same day when the Inspector requested training record, the DOC reported that the PSW's completed their IPAC annual training that day after the Inspector had requested the PSW's annual IPAC training and they realized it was not complete.

Failing to ensure a PSW's annual IPAC retraining was completed may have increased the chance for infection to be spread in the home.

Sources: training record for the PSW, interview with the IPAC lead and DOC.

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary:
The long-term care home documented all air temperature records on an electronic log. On review of the air temperature record for the month of June 2024, there were a number of days where air temperatures for resident rooms were not maintained at a minimum temperature of 22 degrees Celsius.

The home received message notifications when monitored air temperatures fall

below 22 degrees Celsius. Review of event log forms documented actions taken indicated windows were being closed to prevent the air conditioning from working hard, the boiler was identified non-operational, and services from Heating, Ventilation, and Air Conditioning and plumbing were requested.

Interview with Environment Services Manager indicated that the home's system of heating should be activated when air temperatures drop too low, however it was not operational because a boiler required remedial maintenance. During the period that the home was awaiting external services to conduct remedial repairs, Maintenance staff indicated that one resident requested a space heater and as such received the space heater as requested. There were no other documented actions taken to ensure air temperatures were maintained at a minimum of 22 degrees Celsius or to provide comfort.

Failure to maintain the home's air temperatures at a minimum temperature of 22 degrees Celsius affects resident comfort.

Sources: air temperature records, alert event log form, interviews with Environmental Services Manager, Maintenance staff, and Administrator.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 7.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.

The licensee has failed to ensure that a resident's plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.

Rationale and Summary:
A resident was admitted to the home on a specific date. A plan of care was developed for the resident for activities of daily living including dressing, personal hygiene, and mobility. The plan of care for the activities of daily living did not specify the type and level of assistance that the resident required.

Interviews with a PSW indicated the plan of care did not adequately indicate the resident care needs and required to be revised. The PSW indicated that the resident required specific type and level of assistance for dressing, personal hygiene and mobility.

The DOC indicated that the resident's plan of care was not completed and was required to be completed by the admission nurse when they spoke to the resident and their family. They indicated that the registered nursing staff, including the registered practical nurse on the floor, were responsible to develop the written plan of care for the resident.

There was risk identified when a resident's plan of care was not developed based on an interdisciplinary assessment of physical functioning and the type and level of assistance related to the resident's activities of daily living.

Sources: clinical record, interviews with the DOC and staff.

WRITTEN NOTIFICATION: BATHING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident received a bath twice weekly.

Rationale and Summary:
Interview with the resident indicated that they would miss their scheduled bath and that there would sometimes be another bed bath made up on another day.

Review of clinical record showed that staff documented "activity did not occur" for the resident's bathing on a number of days. There were no identified baths that were made up for the missed activity on scheduled baths.

Interview with a PSW, indicated that the resident was to receive scheduled baths twice weekly. They indicated that the resident sometimes reported to them that baths were missed. The PSW indicated that on a daily basis they would assist the resident to wash up.

Interview with the Director of Care (DOC) indicated that the expectation was that if a bath activity was missed then care staff was responsible to inform the team so that a missed bed bath could be made up.

Failure to ensure that a resident received bathing twice weekly at minimum affects personal hygiene, and quality of life.

Sources: clinical record, interviews the resident, the DOC and staff.

WRITTEN NOTIFICATION: PERSONAL ITEMS AND PERSONAL AIDS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee has failed to ensure that each resident of the home has their personal items, including personal aids such as dentures and hearing aids are labelled.

Rationale and Summary:
During the initial tour a resident's call bell was checked in a shared bathroom. While checking the call bell in the shared bathroom the Inspector observed an unlabeled denture cup, one unlabeled toothbrush and toothpaste in a kidney basin and another unlabeled toothbrush in the home's clear plastic cup, located on the counter in the resident's shared washroom. A PSW agreed the unlabeled personal items in the shared washroom should be labeled.

In an interview with the IPAC lead they agreed that residents that share a washroom

should have their personal items labelled.

There is an increased risk of infection when personal items are not labelled in a shared washroom as the resident and staff may not be aware of which resident the personal belonging belongs too.

Sources: Observation and interview with staff and the IPAC lead.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure monitoring of a resident's responses to, and the effectiveness of their pain management strategies was performed by staff.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a pain management program in place and that this program is complied with.

Specifically, the home did not comply with the licensee's policy entitled "Pain Identification and Management" which required nursing staff to assess the effectiveness of pain control strategies pre- and post-intervention and determine if the effect of the intervention meets the resident's goal for pain management or if

the pain intervention requires adjustment and required care staff to observe the resident each shift for pain and document on the daily care record. The policy directed that a plan of care will be developed based on the history and current assessment and will include the resident's pain control goals and values. The policy stated that these strategies and interventions included on the care plan will be reviewed and evaluated, at minimum quarterly, and more often as necessary on an individualized assessment.

The Registered Nurses' Association of Ontario's best practice guideline "Assessment and Management of Pain" recommended minimizing adverse effects of pharmacological interventions including prevention, assessment, and management of adverse effects during administration of specific analgesics. It indicated that nurses and interprofessional teams must frequently monitor a person's response to specific analgesics to ensure the person's safety.

Rationale and Summary:
As part of a proactive compliance inspection, a resident was observed for administration of a specific drug. On a specific date, the resident was observed receiving a scheduled analgesic drug for pain administered by a Registered Practical Nurse (RPN). The RPN indicated that pain assessment is not done prior to administering routine analgesic and indicated that their electronic medication administration record (eMAR) did not ask for pain assessment for routine analgesic. The RPN indicated that the resident would receive a pain assessment if there was presence of pain.

Review of clinical record indicated that the resident was started therapy with the analgesic drug on a specific date. Clinical record indicated the resident received a pain assessment on a specific date. There was no pain assessment completed and documented after this date. Clinical record also indicated that the resident's pain

level was documented on a number of days in a five month period, between this specified period there were no other documented pain levels. The daily care record for pain monitoring indicated that there was no documentation found.

The DOC indicated that the expectation for staff was to monitor the resident daily for pain and any changes and that monitoring was to be documented only when there was presence of pain, upon new admission to the home and readmission. They indicated that they did not expect staff to conduct a pain assessment unless triggered that the resident was experiencing increased or worsened pain. The DOC confirmed that the most recent pain assessment that the resident received was on the specified date.

Failure of the licensee to ensure staff were documenting the effectiveness of the resident's responses to pain control and care staff to document observations on the daily care record, poses gaps to the oversight of staff monitoring for resident safety and pain control.

Sources: clinical record, the licensee's policy entitled Pain Identification and Management, Registered Nurses' Association of Ontario's Assessment and Management of Pain (2013; Third Edition) Clinical Best Practice Guidelines, interview with staff, and Director of Care.

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

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

Rationale and Summary:
A proactive compliance inspection was conducted at the long-term care home and included observations for three residents at nutritional risk. A diet book was observed readily accessible at the servery during meal service. The daily notes from the diet book indicated information on two resident's diets, special needs and preferences.

Review of residents' clinical record indicated additional information on meal preferences that was not mentioned in the diet book at meal service.

The licensee's policy entitled Meal Service and Dining Experience stated that meals will be appetizing, served at the appropriate temperature, meet the residents' dietary needs, special needs, and preferences with an emphasis on food safety. The policy indicated that dietary staff were to refer to diet list when plating meals as per resident selection during meal service.

During interviews, Dietary Manager indicated that Dietary Aides do not have access to the residents' clinical record. Dietary Manager acknowledged that the information on resident diet preferences should be consistent between the diet book and clinical record, and that it was the responsibility of registered staff to communicate updates to a resident's diet, needs and preferences, to the dietary department.

Failure to ensure food service workers and other staff assisting are aware of residents' meal preferences impact pleasurable mealtime and dining experiences.

Sources: observations, diet book, clinical record, licensee's policy Meal Service and Dining Experience, interviews with the Registered Dietitian and Dietary Manager

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to indicate the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.
The licensee has failed to ensure a written record of the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,

Rationale and Summary:
The home's Quality Improvement initiatives was reviewed as part of the home's Proactive Compliance Inspection. The Continuous Quality Improvement initiative report for 2023-2024, indicated that the home had three quality indicators and change ideas for resident centered experience. Review of the home's Continuous Improvement initiative for 2024-2025 posted on their website indicated the quality indicators for the resident/ family experience survey for 2023, however the website did not include the resident centered indicators from the previous year and a summary of what was implemented, and the outcomes of those actions.

Prior to the interview the inspectors and the Quality Risk Manager Coordinator (QRMC) reviewed the website and discussed the report. The Quality Risk Management Coordinator (QRMC) agreed the homes Continuous Quality Improvement initiative report posted on the home's website did not include the dates the actions implemented and the outcomes for the previous year's indicators, chosen for improvement.

When the licensee did not indicate on the website the actions taken, the dates and the outcomes to improve the long term care home for their chosen quality indicators, the home did not maintain transparency.

Sources: Quality Improvement Plan (QIP) Narrative for Health Care Organizations Ontario, the home's Quality Improvement Plan, interview with the QRMC.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licenses has failed to ensure any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions.

Rationale and Summary:
During the home's Proactive Compliance Inspection the home's Quality Improvement initiatives were reviewed which included reviewing the home's website. The website included a narrative under the heading access and flow, which indicated that they Implemented an Admissions Coordinator in 2023, which allowed increased communication and connection with HCCSS partners and increased successful transitions for residents and family members into the Long Term Care Home. The website also indicated they were successful in utilizing the Virtual Behavioural Response Team in 2023 in implementing tools that increased the quality of life for residents. However, this was the only part of the quality improvement that indicated the year the interventions were implemented, and the outcome. The home's active areas for quality improvement for 2024-2025 included quality indicators for Falls Prevention, Inappropriate use of Antipsychotics, Restraint Reduction, Worsened Stage 2-4 Pressure Injury, the quality indicators from the

previous year, 2023-2024, did not included the dates the actions were implemented and the outcomes of the actions.

Prior to the interview the inspectors and the Quality Risk Manager Coordinator (QRMC) reviewed the website and discussed the report. In an interview with the Quality Risk Management Coordinator (QRMC) they agreed the quality indicators for the previous year and whether the outcomes were met from the actions they took, the dates, how it was completed and how it was implemented for those indicators were not posted on the home's website.

There is a lack of transparency when the outcomes, the actions taken, the dates, how it was completed and how it was implemented for the home's indicators was not posted on the website.

Sources: The home's Quality Commitment website, interview with the QRMC.

COMPLIANCE ORDER CO #001 RESTORATIVE CARE

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 13 (1) (a)
Restorative care
s. 13 (1) Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that,
(a) promotes and maximizes independence;

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

1. The home will implement the restorative care program as outlined in the home's policy. Keep a record of the policy and documentation of how the restorative program was implemented as per policy. Provide the policy and the record of how the restorative care program was implemented, upon request of the inspector.

Grounds
Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that, promotes and maximizes independence.

Rationale and Summary:
As part of the proactive compliance inspection the home's Falls Prevention and Management Program was reviewed and the home's Quality Improvement. The falls lead also the home's Quality and Risk Manager Coordinator (QRMC) indicated that despite falls interventions their falls indicator had increased. The home's quality initiatives posted on their website indicated that through their restorative care programs they work with residents to encourage them to do tasks such as eating, dressing, toileting, and walking, on their own. Their approach is to ensure that each resident with assessed needs is able to maintain or improve their functional and cognitive capacity to the best of their ability in all aspects of daily living.

The home's policy titled Restorative Care Program indicated that homes will adopt a restorative care philosophy and ensure that restorative approaches are integrated into care provide to all residents. Homes will provide specific restorative care interventions in a coordinated, interdisciplinary team. The Extendicare Restorative nursing guide indicated the resident has a right to be involved in their care and should receive the most appropriate support to achieve their optimal level of functioning and improve their quality of life. All homes will implement a continuum of restorative care and services in keeping with available funding and regulatory,

requirements, including restorative nursing care aimed at improving function, promoting decline in function, promoting independence, fostering self-efficacy and self-esteem.

The home's policy titled Falls Prevention and Management indicated post resident fall staff to refer to Restorative Care Program, physiotherapist/occupational therapist, Dietitian, housekeeping, maintenance and other members of the interdisciplinary team for follow up as appropriate.

In an interview with the QRMC they acknowledged the home's nursing restorative program was not currently implemented in the home and they were working on getting a lead for the Restorative Program and getting the restorative program back up and running.

There was an increased risk and impact to the residents when the restorative program was not interdisciplinary and the nursing restorative program was not implemented as the resident's independence to maintain their function to perform activities of daily living may have declined, affecting their quality of life.

Sources: The licensee's policy titled Restorative Care Program and Nursing Restorative Guide, Falls Prevention and Management Program, the home's quality initiative website, interview with the home's Quality Risk Manager Coordinator.

This order must be complied with by October 18, 2024

COMPLIANCE ORDER CO #002 DOORS IN A HOME

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1) The Environmental Services Manager or Administrator will conduct physical checks on a specific resident home area to ensure all doors that lead to non-residential areas are kept locked when not being supervised by staff. The physical checks will be done by attempting to open the door by turning the door handle/knob. The frequency of checks shall be three times a week for a period of three weeks.

2)) Retain documentation of the physical checks on the resident home area. The documentation shall include the audit date, auditor name, any deficiencies, any actions taken, and date of any actions taken. Immediately provide the documentation to any inspector when requested for review.

Grounds
The licensee has failed to ensure a door leading to a non-residential area was kept locked when they are not being supervised by staff.

Rationale and Summary:
On initial tour of the home, a door to the clean utility room was observed to be closed over but not locked, located in a resident home area. Materials kept in the

room included a hydrocollator unit with a danger sign indicated "hot." At the time of the observation the area was not supervised by staff. A resident was also observed wandering in the home area hallways.

An activities aide indicated that the door to the clean utility should be locked when closed. The activity aide demonstrated the use of the keypad door lock and found that the door was not secured after the door swung closed with lock activated. The Administrator was made aware and indicated that the door lock was fixed by maintenance later that day.

There was risk identified when the licensee failed to ensure a door leading to a non-residential area was kept locked when unsupervised by staff.

Sources: observations, interviews with Administrator and staff.

This order must be complied with by October 18, 2024

COMPLIANCE ORDER CO #003 TRANSFERRING AND POSITIONING TECHNIQUES

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1) Director of Care or the Assistant Director of Care will conduct auditing on daily care record to ensure two residents are receiving the physical assistance as per written plan of care for continence care or toileting. The frequency of auditing shall be three times a week for a period of three weeks.

2) Retain documentation of the daily care record auditing. The documentation shall include the audit date, auditor name, resident name, any deficiencies, any actions taken, dates of any actions taken, any staff names who received re-instruction. Immediately provide the documentation to any inspector when requested for review.

Grounds
(1) The licensee has failed to ensure that staff used safe positioning techniques when repositioning a resident in a bed.

Rationale and Summary:
As part of the inspection, three residents were reviewed for resident care and services.

A resident had physical impairment and required physical assistance for care. A plan of care was implemented for the resident for transferring and continence care. A plan of care was implemented for continence care requiring total dependence of two staff providing extensive assistance.

Interview with the resident indicated that they sometimes received one staff physical assistance with continence care. Review of daily care record indicated that the resident sometimes received one-person physical assistance with continence care.

Interview with a Personal Support Worker (PSW) indicated that they sometimes provided one staff physical assistance during continence care for the resident.

There was risk identified when staff did not provide safe techniques and physical assistance as per the plan of care.

Sources: clinical record, interviews with the resident and staff.

(2) The licensee has failed to ensure that staff used safe transferring techniques to transfer a resident.

Rationale and Summary:
As part of the inspection, three residents were reviewed for resident care and services.

A resident had cognitive and physical impairment and required physical assistance for care. A plan of care was implemented for the resident for transferring indicating to utilize a specific positioning device for all transfers.

Interview with a PSW indicated that they provided assistance to the resident using a different positioning device to assist for specific care. The Director of Care (DOC) indicated that transferring method as assessed for the resident should be utilized.

Failure to ensure that staff utilized safe positioning devices as per the resident's plan of care may pose a risk of injury.

Sources: clinical record, interviews with staff and the DOC.

This order must be complied with by October 18, 2024

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

There was previous compliance history of O. Reg 246/22 s. 40 Transferring and positioning techniques. A Voluntary Plan of Correction was issued on inspection #2021_887111_0015 dated September 1, 2021 and a Compliance Order was issued on inspection #2023-1409-0003 dated August 18, 2023.

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

COMPLIANCE ORDER CO #004 DESIGNATED LEAD

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 70 (1)
Designated lead
s. 70 (1) Every licensee of a long-term care home shall ensure that the home's restorative care program, including the services of social workers and social service workers, are co-ordinated by a designated lead. O. Reg. 246/22, s. 70 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
The Administrator will designate and train a lead for the home's restorative care program, and to coordinate the services of social workers and social service workers. Keep a documented record of the name of home's designated lead for the restorative care program. Provide the name of the lead upon request of the inspector.

Grounds
The licensee has failed to ensure that the home's restorative care program,

including the services of social workers and social service workers, are coordinated by a designated lead.

Rationale and Summary:
As part of the home's proactive compliance inspection the Falls Prevention and Management Program was reviewed and the home's Quality Improvement. The falls lead also the home's Quality and Risk Manager Coordinator, indicated that despite new fall interventions their falls indicator had increased. The falls lead indicated the restorative care program was not currently implemented as the home did not have a restorative care lead.

Resident council meeting notes indicated that a new social worker was hired, the home was figuring out their exact role and responsibilities but for now they would be working alongside the activities team and the admissions coordinator to get to know the home and residents.

The licensee's policy titled Restorative Care Program indicated that the home will provide specific restorative care interventions in a coordinated, interdisciplinary team approach to ensure that each resident with assessed needs is able to maintain or improve their functional and cognitive capacity to the best of their ability in all aspects of daily living. The Restorative care aims to enhance the physical and cognitive function of people who have lost or are at risk of losing condition/functional status. Achieved through active involvement in low intensity therapy and personal care support and interventions aimed at helping residents improve and/or prevent decline in functional status and independence. The procedure indicated to designate a registered staff member as the Restorative Care Lead for the home and arrange the necessary education to prepare the Restorative Care Lead for their duties and responsibilities.

The residents may have been at risk for increased risk for falls when the home did not have a designated lead for the home's restorative program to ensure the resident's needs were assessed to maintain independence and improve their functional capacity. The home not having a restorative care lead to coordinate the social worker visits may have impacted the resident as their cognitive functional needs may not have been met.

Sources: The licensee's policy titled Restorative Care program, resident council meeting notes, interview with the Quality and Risk Manager Coordinator.

This order must be complied with by October 18, 2024

COMPLIANCE ORDER CO #005 INFECTION PREVENTION AND CONTROL PROGRAM

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. The IPAC lead or designate will post signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring and the steps that must be taken if an infectious disease is suspected or confirmed in any individual. Keep a documented record of the where these posted signs are located throughout

the home.

2. The IPAC lead or designate will educate all registered staff, PSW's and housekeeper's that work and provide care on Mowat House the process to follow when a hand sanitizer is noted to be empty in a resident's room. Keep a documented record of the process, the names of the staff educated, and the date of the education. Provide the documentation upon request to the inspector.

3. The IPAC lead or designate will implement a process to ensure resident bedpan and washbasins are not stored on the floor in resident bathrooms and bedpan and washbasins are labeled. Once the process is implemented the IPAC lead or designate will educate all PSW and registered staff, using a method of their choice. Once staff are educated the IPAC lead or designate will audit once a week for one month all resident washrooms to ensure the basins and bedpans are not stored on the floor, and they are labelled in the residents' washrooms. If the IPAC lead notes the washbasins or bedpan is on the floor, or it is not labeled the IPAC lead will provide education to the staff. Keep a documented record of the process, the content of the education and method the education was provided to staff. Keep a record of the weekly audit including of the date the audit was completed, the resident's room number, and the name and date of the staff that required re-education and what re-education was provided. Provide the documentation upon request to the inspector.

Grounds

1) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

The licensee has failed to ensure the infection prevention and control program related to routine cleaning and disinfection of resident care equipment, storage of

equipment, environmental controls, and making hand hygiene product available in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023. Specifically, minimum routine practices - use of controls including 9.1 (e) (i) Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available;

Rationale and Summary:
As part of the home's Proactive Compliance Inspection (PCI), and initial tour of the home was completed. A resident was notified the inspectors were completing an PCI inspection in the home. The Inspector observed upon entering there was no hand sanitizer available in the dispenser. In an interview that same day the housekeeper working on the unit reported they checked the hand sanitizers daily when they clean the residents rooms.

A day later, the hand sanitizer remained empty, the housekeeper was aware of the Inspector's observation and reported they would change it right away. Five days after, the inspector was conducting an interview with the same resident, the hand sanitizer dispenser remained empty. The home's Quality Risk Management Coordinator (QRMC) was aware of writer's observation and reported they would follow up with the Environmental Service Manager. A few days later, the Inspector visited the resident and the hand sanitizer dispenser was observed to have been replaced and alcohol based hand rub was available.

In an interview the IPAC lead they reported all staff were to ensure alcohol based hand sanitizer dispensers were working and if they were empty staff were to report it the housekeeper or them to ensure the alcohol based hand sanitizer was replaced and the dispenser was operational.

There was a increased risk for the spread of infection to residents when the hand sanitizer dispenser was not operational for several days.

Sources: Observation of a resident room, interviews with staff and the IPAC lead.

2) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

The licensee has failed to ensure the infection prevention and control program related to posting signage at entrances and throughout the home that listed the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease was suspected or confirmed in any individual, in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023. Specifically posting signage throughout the home that lists the signs and symptoms of infectious disease for self-monitoring as well as steps that must be taken if an infectious diseases is suspected or confirmed in any individual, under New Additional Requirement Under the Standard, Additional screening requirements 11.6, under the IPAC Standard.

Rationale and Summary:
The home's entrance indicated there were signs posted on the front entrance indicating to not visit if they had an infectious disease, the sign listed the symptoms, and what to do if they had symptoms, however there were no signs posted throughout the home that listed the signs and symptoms of infectious disease or for self-monitoring nor the steps that must be taken if an infectious diseases is suspected or confirmed in an individual.

The IPAC lead and inspector observed the second floor and they agreed signs were

not posted as per the IPAC standard 11.6, which indicated signs were to be posted throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual. The IPAC lead reported to the Inspector they would post the signs throughout the home as per the IPAC standard.

By not posting signs throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual there is a risk of spreading infectious disease to the staff and residents.

Sources: Observation, interview with the IPAC lead.

3) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 5.5, directs, the licensee shall identify how IPAC policies and procedures will be implemented in the home.

Rationale and Summary:
The home's policy titled Personal Care Equipment: Cleaning and Disinfecting indicated to store dedicated washbasins labelled with the resident's name in a clean and sanitary manner in the resident's room bed environment, non-dedicated are to be stored in the clean utility areas. Store dedicated bed pans in a clean and sanitary manner in the resident's room. Non-dedicated bed pans are to be stored in a clean utility area.

During the initial tour, a resident's call bell was checked in a shared bathroom. While checking the call bell in the shared bathroom the Inspector observed a wash basin was a under the sink, on the floor. A PSW agreed the wash basin was on the floor, as this was where they were kept. That same day while walking by a resident bedroom, a bedpan was observed on the floor under the sink in the resident washroom.

In an interview with the IPAC lead they reported that from a IPAC point of view, resident's wash basins and bed pans should not be stored on the floor and the home had ordered racks to address this.

Improperly stored wash basin's, and bed pans in washroom, places residents at risk for infections, especially in shared spaces.

Sources: Observations in the home, and interview with staff and the IPAC Lead.

This order must be complied with by October 18, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #005

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

There was previous compliance history of O. Reg 246/22 s. 102 (2) (b) Infection prevention and control program. A Written Notification was issued on inspection #2022-1409-0002 dated December 16, 2022, and a Compliance Order was issued on inspection #2023-1409-0003 dated August 18, 2023.

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

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

COMPLIANCE ORDER CO #006 INFECTION PREVENTION AND CONTROL PROGRAM

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. The IPAC lead will educate themselves on all the requirements under section 259 (2) of the Regulation.

2. The IPAC lead will review the staff's orientation and annual education for section 259 (2) of the Regulation, section a to h, and ensure the education contains all the necessary training to comply with this regulation. Keep a documented record of any missed education and any necessary changes that were made to ensure the IPAC education provided to staff annually and upon orientation contained the required education to meet the legislation. Keep a documented record of what education was missing, what education was added to meet the legislation, section a to h, and the date the changes were made, upon request of the inspector.

3. The IPAC lead will develop a process to ensure that all staff are trained on all

required IPAC annually, on a learning platform. Keep a documented record of the process developed to ensure staff are trained annually and name of the person who will be responsible for implementing the process and ensuring staff are trained annually on IPAC practices. Provide the documentation upon request of the inspector.

Grounds
The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home: overseeing the delivery of infection prevention and control education to all staff.

Rationale and Summary:
The home's IPAC lead reported they worked at the home full time and their primary role at the home was IPAC.

During the inspection the IPAC lead and inspector reviewed the annual IPAC training delivered on a learning platform for a PSW. The IPAC lead acknowledged that the PSW did not received their annual IPAC training and should have.

The IPAC lead reported the education for IPAC was completed on the learning platform for new staff and annually, this education was set by Extendicare Corporate. The IPAC Lead reviewed the orientation and annual training package as delivered on the learning platform and agreed the retraining and orientation for new staff did not include respiratory etiquette and infectious signs and symptoms and this education should and would be added to the staff's annual retraining and orientation.

When the IPAC lead did not ensure that a PSW received their annual IPAC training and when the IPAC orientation and retraining did not include respiratory etiquette

and infectious signs and symptoms the residents there may have been an increased risk for the spread of infectious diseases.

Sources: training record, interview with the IPAC lead.

This order must be complied with by October 18, 2024

COMPLIANCE ORDER CO #007 ORIENTATION

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

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

1. The IPAC lead or designate will ensure that education related to signs and symptoms of infectious disease is added to the staff's orientation package and to the annual IPAC training.

2. The IPAC lead or designate will provide education either through online learning or in person, on the signs and symptoms of infectious diseases, to all staff working at the home. Keep a documented record of the content of the training and how the training was completed. If in person training is provided to all staff working at the home, including agency staff the IPAC lead or designate will have staff sign their

name and the date the training was completed. If online learning is the education route provided to staff the IPAC lead or designate will print off the online learning graph by the Compliance due date to indicate the date and the percentage of staff, including agency staff that have completed the training, if the number does not add up to 100% provide the reason why those staff have not been trained must be included in the documentation. Provide the documentation upon request to the inspector.

Grounds
The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82, signs and symptoms of infectious diseases, included (c) signs and symptoms of infectious diseases.

Rationale and Summary:
Review of the home's IPAC training with the home's IPAC lead indicated it did not include signs of symptoms of infectious diseases.

The IPAC lead reported the staff's annual retraining and orientation for IPAC education was set by Corporate. The IPAC Lead reviewed the IPAC training delivered to new staff on orientation and annually to all staff. The IPAC Lead agreed the signs of symptoms of infectious diseases was not included and needed to be added.

By not including the signs and symptoms of infectious diseases in the home's orientation for new staff and annually there may have been an increased risk of staff not recognizing the signs and symptoms and therefore infectious disease may have spread among the home's residents.

Sources: Review of the home's online learning package with the IPAC lead and an

interview with the IPAC lead.

This order must be complied with by October 18, 2024

COMPLIANCE ORDER CO #008 ORIENTATION

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1. The IPAC lead or designate will ensure that education related to respiratory etiquette is added to the staff's orientation package and to the annual IPAC training.

2. The IPAC lead or designate will provide education either through online learning or in person, on respiratory etiquette, to all staff working at the home. Keep a documented record of the content of the training, how the training was completed. If in person training is provided to all staff working at the home, including agency staff the IPAC lead or designate will have staff sign their name and the date the training was completed. If online learning is the education route provided to staff the IPAC lead or designate will print off the online learning graph by the Compliance due date to indicate the date and the percentage of staff including agency staff that have completed the training, if the number does not add up to 100% provide the reason why those staff have not been trained must be included in the

documentation. Provide the documentation upon request to the inspector.

Grounds
The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82, included (d) respiratory etiquette.

Rationale and Summary:
Review of the home's IPAC training with the home's IPAC lead indicated it did not include respiratory etiquette.

The IPAC lead reported the staff's annual retraining and orientation for IPAC education was set by Corporate. The IPAC Lead reviewed the IPAC training delivered to new staff on orientation and annually to all staff. The IPAC Lead agreed respiratory etiquette was not included and needed to be added.

There may have been a increased risk for the spread of infection when staff did not receive respiratory etiquette as part of their orientation.

Sources: Review of the home's online learning package with the IPAC lead and an interview with the IPAC lead.

This order must be complied with by October 18, 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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.