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

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| **Report Issue Date:** October 21, 2024 | |
| **Inspection Number:** 2024-1419-0002 | |
| **Inspection Type:**<br>Complaint<br>Follow up | |
| **Licensee:** St. Joseph's at Fleming | |
| **Long Term Care Home and City:** St. Joseph's at Fleming, Peterborough | |
| **Lead Inspector**<br>The Inspector | **Inspector Digital Signature** |
| **Additional Inspector(s)**<br>The Inspectors | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-13, 16-20, 23-27, 2024.

The following intake(s) were inspected:

Intake #00102814 - regarding follow-up #1 on Compliance Order (CO) #002, from inspection #2023-1419-0003, specific to FLTCA, 2021, s. 24 (1). with a Compliance Due Date (CDD) of Apr 12, 2024

Intake #00113964 - regarding follow-up #1 on Compliance Order High Priority CO(HP) #001, from inspection #2024-1419-0001, specific to FLTCA, 2021, s. 6 (4) (a), with a CDD of August 13, 2024.

Intake #00113965 - regarding follow-up #1 on CO(HP) #002 from inspection #2024-1419-0001, specific to FLTCA, 2021, s. 6 (7), with a CDD of August 13, 2024.

Intake #00113962 - regarding a follow-up #1 on CO(HP) #003 from inspection #2024-1419-0001, specific to FLTCA, 2021, s. 24 (1), with a CDD of August 13, 2024.

Intake #00113969 - regarding follow-up #1 on CO(HP) #004 from inspection #2024-1419-0001, Transferring and positioning techniques, specific to O. Reg. 246/22, s. 40, with a CDD of August 13, 2024.

Intake #00113972 - regarding follow-up #1 -, CO(HP) #005 from inspection #2024-1419-0001, Required programs, specific to O. Reg. 246/22, s. 53 (1) 4, with a CDD of August 13, 2024.

Intake #00113973 - regarding follow-up #1 on CO(HP) #006 from inspection #2024-1419-0001, Skin and wound care, specific to O. Reg. 246/22, s. 55 (2) (b) (i), with a CDD of August 13, 2024.

Intake #00113966 - regarding follow-up #1 on CO(HP) #007 from inspection #2024-1419-0001, Pain management, specific to O. Reg. 246/22, s. 57 (2), with a CDD of August 13, 2024.

Intake #00113970 - regarding follow-up #1 on CO(HP) #008 from inspection #2024-1419-0001, Dining and snack service, specific to O. Reg. 246/22, s. 79 (1) 3, with a CDD of June 30, 2024.

Intake #00113971 - regarding follow-up #1 on CO(HP) #009 from inspection #2024-1419-0001, Dining and snack service, specific to O. Reg. 246/22, s. 79 (1) 9, with a CDD of June 30, 2024.

Intake #00113975 - regarding follow-up #1 on CO(HP) #010 from inspection #2024-1419-0001, Infection prevention and control program, specific to O. Reg. 246/22, s. 102 (2) (b), with a CDD of August 13, 2024.

Intake #00113963 - regarding follow-up #1 on CO #013 from inspection #2024-1419-0001 regarding plan of care, specific to FLTCA, 2021, s. 6 (1) (c), with a CDD of June 30, 2024.

Intake #00113967 - regarding follow-up #1 on CO #014 from inspection #2024-1419-0001, Communication and response system, specific to O. Reg. 246/22, s. 20 (a), with a CDD of June 30, 2024.

Intake #00113968 - regarding follow-up #1 on CO #015 from inspection #2024-1419-0001, Nursing and personal support services, specific to O. Reg. 246/22, s. 35 (3) (a), with a CDD of June 30, 2024.

Intake #00113976 - regarding follow-up #1 on CO(HP) #011 from inspection #2024-1419-0001, Infection prevention and control program, specific to O. Reg. 246/22, s. 102 (7) 9, with a CDD of June 30, 2024.

Intake #00113978 - regarding follow-up #1 on CO(HP) #012 from inspection #2024-1419-0001, Infection prevention and control program, specific to O. Reg. 246/22, s. 102 (8), with a CDD of August 13, 2024.

Intake #00113977 - regarding follow-up #1 on CO #016 from inspection #2024-1419-0001, Infection prevention and control program, specific to O. Reg. 246/22, s. 102 (9) (a), with a CDD of August 13, 2024.

Intake #00113974 - regarding follow-up #1 on CO #017 from inspection #2024-1419-0001, Administration of drugs, specific to O. Reg. 246/22, s. 140 (2), with a CDD of August 13, 2024.

Intake #00101066 and Intake #00118130 - complaints related to an unexpected death of a resident.

Intake #00113864 and Intake #00117708 - complaints related to staffing concerns.

Intake #00116378 - a complaint related to concerns with continence care, skin and wound care, quality of food and availability of supplies.

Intake #00118530 - a complaint related to staffing levels, scheduling, neglect of residents' care, and care not being done.

Intake #00119015 - a complaint related to staffing levels and infection control practices.

Intake #00122706 - a complaint related to staffing levels; lack of care, missed bathing and wound care, licensee not investigating allegations of abuse.

Intake #00123787 - a complaint related to an allegation of abuse and improper care.

Intake #00125298 - a complaint related to resident supervision, staffing, housekeeping, care and safety concerns.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1419-0003 related to FLTCA, 2021, s. 24 (1)

Order #001 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 6 (4) (a)
Order #002 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 6 (7)
Order #007 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 57 (2)
Order #004 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 40
Order #008 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 79 (1) 3.
Order #009 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 79 (1) 9.
Order #005 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 53 (1) 4.
Order #006 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 55 (2) (b) (i)
Order #010 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 102 (2) (b)
Order #011 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 102 (7) 9.
Order #016 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 102 (9) (a)
Order #012 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 102 (8)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #003 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 24 (1)
Order #013 from Inspection #2024-1419-0001 related to FLTCA, 2021, s. 6 (1) (c)
Order #014 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 20 (a)
Order #015 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 35 (3) (a)
Order #017 from Inspection #2024-1419-0001 related to O. Reg. 246/22, s. 140 (2)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (5)**

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure the resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care when they had a change in condition.

**Rationale and Summary**

A Critical Incident (CI) was submitted to the Director reporting an allegation of neglect of a resident. The resident had a change in condition requiring transfer to the hospital.

The resident's clinical health records indicated a Registered Practical Nurse (RPN) reported to a Registered Nurse (RN) that the resident had a change in condition. The RPN confirmed they did not inform SDM.

By failing to ensure staff informed the SDM of the resident's change in condition, the SDM was prevented from requesting the resident be sent to the hospital or that the physician or Nurse Practitioner (NP) be called. This put the resident at risk of delayed treatment.

**Sources**: resident clinical health records, a CI, and interview with staff.

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision for bathing set out in the plan of care for a resident was documented.

**Rationale and Summary**

A complaint was submitted to the Director regarding residents' missing their scheduled baths due to staffing shortages.

A resident was scheduled for two baths per week. For a one-month period, there was missing documentation on three occasions. A PSW, and RPNs reported

residents' may miss their scheduled bath due to staffing shortages. There were staffing shortages on the three occasions.

Failure to ensure the provision of care set out in the resident's plan of care was documented placed the resident's well-being at risk due to a decreased ability to effectively monitor and evaluate their interventions.

**Sources:** resident clinical health records, licensee records and interviews with staff.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 1.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the person having reasonable grounds to suspect improper care of a resident, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

**Rationale and Summary**

A complaint was submitted to the Director reporting improper care of a resident.

A RN reported the allegations of improper care of a resident to three managers. An

internal investigation was conducted. Documentation indicated the reporting of the incident did not match what was found.

A CI report regarding the allegations of improper care or a call to the Ministry's after-hours line was not found.

By failing to report allegations of staff to resident improper care to the Director further incidents could occur without proper follow-up.

**Sources:** resident clinical health records, and the Ministry of Long-Term Care Portal.

## WRITTEN NOTIFICATION: Conditions of licence

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with compliance order (CO) #014 from Inspection #2024-1419-0001 served on April 15, 2024, with a compliance due date of June 30, 2024.

The required daily call bell audits were not fully documented for a period of four weeks with the corrective measures to correct the non-compliance when the resident's call bell was not within reach.

**Rationale and Summary**

CO #014 indicated to conduct daily audits for a period of fours week to ensure

several identified residents' had their call bell within reach. Review of the call bell audits indicated that on five days there were no call bell audits to review. The call bell audit for the compliance order also included the auditor to indicate if there were any areas of non-compliance and the corrective measure taken to correct the non-compliance. On several call bell audits the auditor did not document the corrective measures on the audit when noncompliance was identified.

The Director of Resident Care (DRC) agreed the daily call bell audit was missed on five separate occasions over the four-week auditing period. The DRC further agreed that on multiple resident call bell audits the corrective measures taken to correct the non-compliance was not documented.

**Sources:** CO #014 from inspection #2024-1419-0001, review of CO #014 call bell audits, interview with the DRC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #004**

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 an order under s. 155 of the Act.

**Compliance History:**

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.

## WRITTEN NOTIFICATION: Conditions of licence

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with CO #013 from inspection #2024-1419-0001 served on April 15, 2024, with a compliance due date of June 30, 2024.

1) Specifically, resident #007's plan of care to apply medicated treatment creams did not provide clear direction.

**Rationale and Summary**

The resident's electronic Medication Administration Record (e-MAR) and electronic Treatment Administration Record (e-TAR) did not provide clear direction regarding the application of the medicated treatment creams. Home Area Manager (HAM)

#114 was designated to ensure the resident's plan of care provided clear direction regarding medicated treatment creams. HAM #114 acknowledged the resident's e-MAR and e-TAR did not provide clear direction related to medicated treatment creams.

**Sources:** Resident #007's Care Plan, e-MAR and e-TAR, and interview with HAM #114.

2) Specifically, resident #005's plan of care for continence care and mobility needs did not provide clear direction.

**Rationale and Summary**

The resident's written care plan did not provide clear direction regarding the resident's continence care and mobility needs. HAM #107 was designated to ensure the resident's plan of care provided clear direction regarding continence care and mobility needs. HAM #107 acknowledged the resident's written care plan did not provide clear direction related to the resident's continence care and mobility needs.

**Sources:** Resident #005's Care Plan, and interview with HAM #107.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #005**

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 an order under s. 155 of the Act.

**Compliance History:**
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.

## WRITTEN NOTIFICATION: Conditions of licence

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with CO #015 from inspection #2024-1419-0001 served on April 15, 2024, with a compliance due date of June 30, 2024.

Specifically, there was no documentation of a brief description of the contingency plan implemented on each shift when staffing shortages occurred or when resident care needs were not met.

**Rationale and Summary**

The DRC acknowledged that a brief description of the staffing contingency plan when there were staffing shortages had not been implemented.

**Sources:** Charge Nurse Report Sheets, and an interview with DRC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #003**
**Related to Written Notification NC #006**

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 an order under s. 155 of the Act.

**Compliance History:**
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.

## WRITTEN NOTIFICATION: Conditions of licence

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 104 (4)**

Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with CO #017 from Inspection #2024-1419-0001 served on April 15, 2024, with a compliance due date of August 13, 2024.

The required education of all the registered nursing staff, including agency, and HAMs, on the contingency plan developed was not completed and the education records where not kept.

**Rationale and Summary**

All registered staff, including agency, and HAMs were not educated on the contingency plan developed to identify which registered nursing staff member will assist with the medication pass if the registered nursing staff member already assigned to a Resident Home Area (RHA) is unable to administer all medication and treatments, in a timely manner, especially when short staffed.

In addition, records including name of person providing the education, contents of the education, dates, names, and signature of staff educated, were not kept.

**Sources**: CO #017 from #2024_1419_0001, review of education records and an interview with the DRC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #004**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #004**
**Related to Written Notification NC #007**

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 an order under s. 155 of the Act.

**Compliance History:**
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.

## WRITTEN NOTIFICATION: Conditions of licence

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with CO #003 from Inspection #2024-1419-0001 served on April 15, 2024, with a compliance due date of August 13, 2024.

The required education of all the registered nursing staff, including agency, on advanced wound care courses was not completed.

**Rationale and Summary**

Education records related to advance wound care courses indicated that all registered staff were not educated on advanced wound care.

**Sources:** CO #003 from #2024_1419_0001, education records and interview with the DRC.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #005**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #005**
**Related to Written Notification NC #008**

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 an order under s. 155 of the Act.

**Compliance History:**
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.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

**Rationale and Summary**

Complaints were submitted to the Director regarding a resident's care needs not being met due to staff deficiencies and continence care not being provided in a

timely manner.

A resident indicated that a second staff member wasn't always available to assist with transfers. Personal Support Workers (PSW) were asked to complete the transfer without a second staff present.

A PSW indicated they transferred the resident without a second staff member when there were staffing shortages. The staffing schedules confirmed there were PSW staffing shortages on a date the PSW transferred the resident without a second staff to assist.

Staff and HAM #114 indicated the resident required two staff be present when the resident transferred.

The resident was at risk of injury when the PSW failed to use safe transferring techniques which would have included a second staff member while transferring the resident.

**Sources:** resident clinical health records, Staffing Schedule, and interviews with the resident, staff and HAM #114.

## WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure a resident received a skin assessment upon return from the hospital.

**Rational and Summary**

A CI submitted to the Director for an allegation of neglect of a resident.

Upon the residents return from the hospital, an RN documented they observed areas of altered skin integrity. Skin and wound assessments were not found in the resident's clinical health records.

HAM #114 confirmed the skin and wound assessments were not completed.

The resident was at risk of a negative outcome when wound assessments were not completed upon their return from hospital.

**Sources:** a CI, resident's health records, confirmation by HAM #114.

## WRITTEN NOTIFICATION: Skin and Wound

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, including skin breakdown was assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

**Rationale and Summary**

A complaint was submitted to the Director regarding allegations that a resident's altered skin integrity and treatment was not managed properly.

The clinically appropriate Skin and Wound Evaluation note was not completed for the resident's altered skin integrity.

HAM #114 acknowledged that registered nursing staff had not completed the clinically appropriate skin and wound evaluation note.

There was an increased risk for skin deterioration when the effectiveness of the skin treatment was not evaluated using the clinically appropriate instrument for skin and wound.

**Sources:** the resident's clinical health records and interviews with the resident, staff, and HAM #114.

## WRITTEN NOTIFICATION: Dealing with Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (2)**
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home

that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

**Rationale and Summary**

A complaint was submitted to the Director regarding resident care needs that were not being met due to staff deficiencies and care not being provided in a timely manner.

A review of a resident's progress notes and an interview with HAM #114 confirmed that the resident had reported care concerns to staff. HAM #114 confirmed there were no internal records for the verbal complaints brought forward by the resident. They indicated they had spoken with the resident on several occasions and the care concerns brought forward by the resident were not documented.

When the licensee failed to retain documented records of the verbal complaints alleging care concerns of the resident, the Inspector was not able to determine the licensee's actions in response to the allegations and the outcome of the licensee's investigation.

**Sources:** resident clinical health records and HAM #114.

## WRITTEN NOTIFICATION: Reporting re critical incidents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to immediately report the sudden death of a resident.

**Rationale and Summary**

A CI was submitted to the Director two days after an unexpected death of a resident

There was minimal risk to the resident when the licensee failed to report the incident immediately to the Director.

**Sources:** a CI.

## WRITTEN NOTIFICATION: Evaluation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 122 (a)**

Evaluation

s. 122. Every licensee of a long-term care home shall ensure,

(a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis;

The licensee has failed to ensure that a monthly analysis of a resident's restraining device.

**Rationale and Summary**

A complaint was submitted to the Director reporting improper restraining of a resident.

A resident was observed on more than one occasion while their restraint was applied. HAM #107 acknowledged a monthly analysis of the restraint use was not completed.

The resident was at risk of harm when restraint use was not analyzed monthly to determine if the restraint use was appropriate for the resident.

**Sources:** Observation and an interview with HAM #107.

## WRITTEN NOTIFICATION: Safe storage of drugs

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

**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a resident's medications were stored in an area which was kept secured and locked.

**Rationale and Summary**

Complaints were submitted to the Director regarding the resident's care needs not being met.

Several medications were observed in an area that was not secure or locked.

HAM #114 confirmed that these medication were not stored correctly.

Residents were placed at risk of possible exposure and/or inappropriate usage/application of multiple medications when the medication was not stored in a secured and locked area.

**Sources:** Observations and interviews with the resident and HAM #114.

## WRITTEN NOTIFICATION: Administration of drugs

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in

accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

**Rationale and Summary**

A complaint was submitted to the Director regarding allegations that a resident's altered skin integrity and medication were not managed properly.

Interviews and documentation reviews confirmed the PSWs were applying the resident's medicated treatment cream, that was prescribed to be applied by the RPN. HAM #114 confirmed the RPNs should be applying the medicated treatment cream, as directed by the Nurse Practitioner (NP).

Failure to ensure that medicated treatment cream was applied by the RPN placed the resident at risk for worsening of their altered skin integrity.

**Sources:** resident's clinical health records and interviews with the resident, staff, and HAM #114.

## WRITTEN NOTIFICATION: Administration of drugs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (6)**
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee has failed to ensure that a resident did not administer a drug to themselves unless the administration had been approved by the prescriber.

**Rationale and Summary**

Complaints were submitted to the Director regarding the resident's care needs not being met.

Resident, RPN, and PSW interviews and documentation review confirmed the resident was self-administering some of their medication and directing the PSWs who were administering treatments for the resident.

The resident did not have a physician order to self-administer medication. The prescriber's orders did not include direction for the resident to self-administer their medication or for the PSWs to administer treatments.

HAM #114 confirmed the prescriber had not approved for the resident to self-administer a medication and the RPNs should be administering all medication.

By not ensuring that the resident did not administer a drug to themselves unless the administration had been approved by the prescriber, placed the resident at risk of possible inappropriate usage of medication.

**Sources:** Observations, the resident's clinical health records and interviews with the resident, staff, and HAM #114.

## COMPLIANCE ORDER CO #001 Plan of care

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 6 (4) (a)**

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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

Specifically, the licensee shall:

1. The DRC is to develop and implement a guidance document to assist Charge RNs in deciding when an assessment of a resident should be completed. This is to include when a staff member reports a change in resident condition to them or an assessment is requested by another staff member. This document should include suggestions of when the physician/NP and the SDM should be notified, who is responsible for the notification and who is to make the decision to send a resident to the hospital.

2. Educate all registered nursing staff, including agency staff and HAMs, on this guidance document.

3. Ensure a documented record is kept pertaining to part one and two of this order including the contents of the education, dates, names, and signature of staff educated and the mode of delivery. Provide the guidance document and education records to the Inspectors immediately upon request.

**Grounds**
The licensee failed to ensure that staff collaborated with each other in their assessment of a resident.

**Rationale and Summary**

A CI was submitted to the Director reporting an allegation of neglect of a resident.

The resident had a change in condition. The RPN reported this to a charge RN. The RN directed the RPN to monitor the resident, inform the oncoming RN to monitor and to make a note in the daily planner for the nurse scheduled for the next day to monitor. No further documentation to support further assessments of the resident could be found until approximately six- and one-half hours later when the resident had gravely deteriorated.

A RPN confirmed the charge RN did not assess the resident when they were informed of the resident's change in condition. The Physician or NP were not consulted.

The oncoming RN on the next shift was informed of the residents change in condition. They looked at the resident when in bed and thought they looked "fine". The resident's condition continued to deteriorate.

HAM #114 indicated that if it was reported to a RN that the resident had a change in condition, they should have assessed the resident and called the physician/NP, the SDM and consider transferring the resident to the hospital.

Staff failed to collaborate in their assessments of the resident which delayed

treatment and may have contributed to a negative outcome.

**Sources:** the resident's clinical health records, a CI, interviews with staff and HAM #114.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #006**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #006**
**Related to Compliance Order CO #001**

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:**
Prior non-compliance with FLTCA, 2021, s. 6 (4) (a) included:
- CO (HP) was issued on April 15, 2024, in inspection #2024-1419-0001.

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 #002 Duty to protect

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or 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 DRC is to develop and implement a process that directs how an investigation is to be conducted by nursing managers after an unexpected death occurs and/or an allegation of staff to resident neglect resulting in death or serious harm. Provide this process to Inspector immediately upon request.

2. Conduct a root cause analysis of all unexpected deaths and allegations of staff to resident neglect resulting in death or serious harm and identify strategies to prevent further occurrence. Ensure this analysis is included in the process indicated in part one.

3. Ensure the process indicated in part two includes review and sign off by the Director of Resident Care after each investigation to ensure all information has been collected and the analysis and strategies developed are appropriate.

4. Keep a documented record of all root cause analyses and strategies as indicated in part two, if applicable, and provide to Inspector immediately upon request.

5. The DRC will educate all Managers in person on this process. Keep a written record of this education including signatures of who was educated, when, who provided the education and the content of the education. Provide this information to the Inspector immediately upon request.

**Grounds**
The licensee failed to ensure that resident #011 was not neglected.

**Rationale and Summary**

A CI was submitted to the Director reporting an allegation of neglect of a resident.

A RPN noticed a resident had a change in condition. They completed an assessment of the resident and updated the charge RN. The charge RN did not assess the resident. The oncoming RN (second RN) who was informed of the resident's change in condition did not document an assessment. No further assessment was documented after the initial assessment until approximately six and one-half hours later when a PSW reported to the second RN, that the resident was in acute distress.

The RPN confirmed the charge RN did not assess the resident when initially

informed that the resident had a change in condition. In addition, the RPN later reported the resident's change in condition to the second RN at the change of shift.

The second RN indicated the resident was "fine" when the PSW's put the resident to bed. That RN did not know the resident's condition had greatly deteriorated until they were informed by PSWs approximately five hours after they received report from the RPN.

HAM #114 indicated that an RN should have assessed the resident and called the physician, the SDM and consider transferring the resident to the hospital.

The failure of staff to collaborate with each other, the physician/NP and the SDM, and the failure to complete appropriate assessments of the resident when the resident had a change in condition was neglectful and caused grave harm to the resident.

**Sources:** the resident clinical health records, the CI, interviews with staff and HAM #114.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #007**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #007**
**Related to Compliance Order CO #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is

required to pay an administrative penalty of $16500.00, 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:**

Prior non-compliance with FLTCA, 2021, s. 24 (1) included:
- CO (HP), AMP #002 for $11,000.00 was issued on April 15, 2024, in inspection #2024-1419-0001.
-CO #002, AMP #003 for $5,500 was issued on November 24, 2023, in inspection #2023-1419-0003,
-WN was issued on November 3, 2022, in inspection #2022-1419-0001.

This is the third 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 #003 Dining and snack service

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 79 (1) 3.**

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:
3. Monitoring of all residents during meals.

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

Specifically, the licensee shall:

1. The Dietician and/or the Food Service Manager are to provide in-person education to all staff, including agency and managers, who supervise or assist with residents in the dining room and/or during nourishments on the supervision/monitoring that is required for residents who require feeding assistance, inclusive of all levels of feeding assistance.

2. Keep a documented record of the education provided, along with attendance records with staff signatures, dates of the education, who provided the education, and the content of the education provided. Make immediately available to Inspectors upon request.

3. Develop a schedule so that at least one manager makes daily rounds of all the dining rooms during lunch and dinner for a period of two weeks, including weekends, to ensure staff are adhering to safe dining practices.

4. A record will be kept of this schedule and be made available to the inspector immediately upon request.

**Grounds**
The licensee failed to ensure resident #008 was adequately monitored during meals.

**Rationale and Summary**

A CI was submitted to the Director for an unexpected death of a resident.

The Dietician documented the resident required extensive assistance with meals and staff were to provide total assistance with eating and monitor the need for further dietary intervention.

Dietician #131 indicated the resident's plan of care was changed to total assist at meals which means the resident would be sitting at a table where staff would assist.

A PSW indicated the resident sat at a table with a group of four residents who were to be closely monitored during meals or assisted with meals. No staff member was sitting at the table at the time of an incident.

A second PSW indicated the resident sat at a supervised table. Usually there should be someone there helping residents that cannot feed themselves. Someone should be there the whole time.

The licensee failed to ensure that the resident was assisted with their meal which put the resident at risk of an adverse event.

**Sources:** a CI, the resident's clinical health records, licensee incident report, and interviews with staff and Dietician #131.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance**

**order AMP #008**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #008**
**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:**
Prior non-compliance with O. Reg. 246/22, s. 79 (1) 3 included:
-CO(HP) was issued on April 15, 2024, in inspection #2024-1419-0001.

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 Dealing with complaints

NC #021 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

**The inspector is ordering the licensee to comply with a Compliance Order []:**

Specifically, the licensee shall:

1. The DRC will provide in person education to HAM #114 on the Legislation - Dealing with Complaints, O. Reg 246/22 s. 108 (1) 1, and the home's policy titled Complaints- Resident or Representative Policy, section: Resident Safeguards and Services. Keep a documented record of the date the education was provided, the content of the education and the signatures of the HAM and DRC to confirm the education was provided. Provide the documentation immediately upon request of the inspector

**Grounds**
The licensee has failed to ensure that a resident's complaints regarding their care was investigated and the resident received a response to their complaint within 10 business days of the receipt of the complaint.

**Rationale and Summary**

A Complaint was submitted to the Director regarding resident care not being met due to staff deficiencies and care not being provided in a timely manner.

A care conference was held for the resident. The Co-Ordinator of Nursing services indicated the resident's biggest concern and frustration was not having their care needs met in a timely manner. The Co-Ordinator of Nursing services reported they would pass on the resident's concerns to the Home Area Manager for follow up.

That same day the Co-Ordinator Nursing services sent an email to HAM #114 indicating that the resident's care conference was held and outlined the resident and their family member's concerns that needed attention/ follow up.

HAM #114 agreed the above resident complaints made by the resident and family as documented in the resident's progress notes and as outlined in the email sent by the Co-Ordinator Nursing services were not investigated.

Failure to investigate and resolve the resident's unmet care needs related to their complaints in accordance with the complaints process, placed the resident at risk for harm. The root cause of the resident's concerns was not identified.

**Sources:** email correspondence, resident's clinical records, interview with the HAM #114.

**This order must be complied with by** December 20, 2024

## COMPLIANCE ORDER CO #005 Requirements relating to restraining by a physical device

NC #022 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 119 (2)**

Requirements relating to restraining by a physical device

s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

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

Specifically, the licensee shall:

1. Within two weeks of receipt of this compliance order HAM #107 or a designated

manager will complete a visual audit for all residents residing on two specified resident home areas to determine which residents have a physical restraint in place.

2. Upon completion of the physical restraint audit, HAM #107 or a designated manager will ensure all residents residing on two specified resident home areas who have a physical restraint in place meet the legislative requirements related to restraining by a physical device. The following requirements must be met:

a) That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

b) That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

c) That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

d) That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

e) That the resident is released and repositioned any other time, when necessary, based on the resident's condition or circumstances.

f) That the resident's condition is reassessed, and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time, when necessary, based on the resident's condition or

circumstances.

3. HAM #107 or a designated nursing manager will conduct random audits on residents residing on two specified resident home areas who have physical restraints in place, twice weekly on different shifts for a period of two weeks to ensure physical restraints meet the requirements according to part 2 (a)(b)(c)(d)(e)(f).

4. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

**Grounds**
The licensee has failed to ensure that the requirements for use of a physical device under section 35 of the Act was met when a resident was being restrained.

**Rationale and Summary**

A complaint was submitted to the Director reporting an improper restraint of a resident.

The resident was observed on more than one occasion to be restrained. The resident's SDM had consented to the restraint several months prior to the inspection. The staff implemented the restraint without a physician or NP order.

HAM #107 confirmed the restraint had been implemented by staff and a physician or NP order was not obtained for the use of the restraint or instructions on how to apply the restraint until several months later. They further acknowledged the resident was not being monitored while restrained at least every hour or released

from the physical device and repositioned at least once every two hours, or any other time, when necessary, based on the resident's condition or circumstances. They further indicated the resident's condition was not reassessed, and the effectiveness of the restraining was not evaluated by a registered staff at least every eight hours, and at any other time, when necessary, based on the resident's condition or circumstances.

The resident was placed at risk for injury and discomfort when the restraint was in place and staff were not monitoring the resident's safety or repositioning the resident.

**Sources:** the resident's clinical health records and interviews with staff, and HAM #107.

**This order must be complied with by** December 20, 2024

## COMPLIANCE ORDER CO #006 Plan of care

NC #023 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

1. Within two weeks of receipt of this CO the HAM or designated registered staff is to

conduct daily audits for a period of two weeks to ensure residents #005, #013, and #014 have received care, as specified in the plan. The following care needs shall be audited.

a) Audit resident #005 to ensure their foot pedals are in place while sitting in their wheelchair, as required based on the resident's assessed care needs.

b) Audit resident #013 and #014 to ensure they have received their scheduled skin and wound care treatment, as required based on the residents' assessed care needs.

2. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

**Grounds**

1) The licensee has failed to ensure that the care set out in the plan of care for resident #005 related to wheelchair foot pedals was provided, as specified in the plan.

**Rationale and Summary**

A follow-up inspection requiring the resident's plan of care to provide clear direction regarding wheelchair foot pedals was being conducted.

Resident #005 was observed on two occasions to be sitting in their wheelchair without foot pedals in place. On one of the occasions the resident's feet were

dangling in the air. On the second occasion a PSW was pushing the resident in their wheelchair and the resident's feet were dragging along the floor.

PSW, RPN, RN, and HAM #107 confirmed the resident required foot pedals while they were sitting in their wheelchair.

The resident was at risk for injury and discomfort when they were not positioned properly with the use of foot pedals while sitting in their wheelchair.

**Sources:** the resident's clinical health records and interviews with staff and HAM #107.

2) The licensee has failed to ensure that the care set out in the plan of care for a resident related to wound care was provided, as specified in the plan.

**Rationale and Summary**

Complaints were submitted to the Director regarding allegations that residents were missing their scheduled wound care, or their wound care was delayed due to staffing shortages.

A resident was scheduled to receive wound care on four specific dates. Record review and interview with RPNs identified there were times when residents did not receive their wound care, as scheduled due to staffing shortages. The staffing schedules confirmed there were RPN staffing shortages on the days the resident did not receive their wound care.

The DRC acknowledged they were not aware that residents care needs were not met due to staffing shortages and that residents had missed their wound care. They

further indicated that a brief description of the contingency plan when there were staffing shortages had not been implemented.

Failure to ensure that wound care was completed as scheduled in the plan of care placed the resident at risk for worsening of their altered skin integrity which could lead to infection.

**Sources:** the resident's clinical health record, licensee records, and interviews with staff, and the DRC.

3) The licensee failed to ensure that a specimen for culture was collected as ordered by the NP.

**Rationale and Summary**

A specimen culture was ordered for a resident. Approximately eight days later, a RPN documented they were unable to collect the specimen. No evidence that a specimen was collected could be found.

A RN indicated the expectation is to collect the specimen as soon as possible within one or two days. If staff are not able to collect the specimen, staff should ask the family and physician/NP if they want an order for a procedure to collect the specimen.

The licensee put the resident at risk of a negative outcome when a specimen was not collected.

**Sources:** the resident clinical health records and an interview with staff.

4) The licensee has failed to ensure that the care set out in the plan of care for a resident related to wound care was provided, as specified in the plan.

**Rationale and Summary**

Complaints were submitted to the Director regarding allegations that residents were missing their scheduled wound care, or the wound care was delayed due to staffing shortages.

A resident was scheduled wound care on four specified days, for two areas of skin impairment. The wound care was not completed. Record review and an interview with a RPN identified the resident did not receive their wound care, as scheduled due to staffing shortages. The staffing schedules confirmed there were RPN and RN staffing shortages on the days the resident did not receive their wound care. The RPN reported they did not receive assistance from the RN, and they were not able to complete the resident's scheduled wound care due to time constraints.

The DRC acknowledged they were not aware that residents care needs were not met due to staffing shortages and that residents had missed their wound care. They further indicated that a brief description of the contingency plan when there were staffing shortages had not been implemented.

Failure to ensure that wound care was completed as scheduled in the plan of care placed the resident at risk for worsening of their altered skin integrity which could lead to infection.

**Sources:** The resident's clinical health records, licensee records, and interviews with staff and the DRC.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #009**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #009**
**Related to Compliance Order CO #006**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:**
Prior non-compliance with FLTCA, 2021, s. 6 (7) included:
- CO(HP) #002, AMP #001 for $1,100.00 issued on April 15, 2024, in inspection #2024-1419-0001.
- WN issued on November 24, 2023, in inspection #2023-1419-0003.
- CO (HP) #001 issued on November 3, 2022, in inspection #2022-1419-0001.

Prior non-compliance with LTCA, 2007, s. 6 (7) included:
-VPC issued on February 10, 2022, in inspection #2021_885601_0023.

This is the second 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 #007 Nursing and personal support services

NC #024 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)**
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

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

1. The DRC is to develop and implement a written process that indicates who is responsible for ensuring resident #007, #012, #013, and #014's care needs are met.

The process developed should include directions to ensure:

a) Residents #012 and resident #013 receive their scheduled skin and wound care treatments, as directed in the plan of care.

b) Resident #007 always receives the required number of staff for transferring and continence care in a timely manner, as directed in the plan of care.

c) Resident #014 receives their scheduled bathing and the details of the care the resident received for bathing is documented.

2. The DRC or management designate are to educate the staff who are responsible for ensuring resident #007, #012, #013, and #014's care needs are met on the processes in part 1. Keep records including name of person providing the education, contents of the education, dates, names, and signature of staff educated.

3. Provide the written process and education documents to the Inspector immediately upon request.

**Grounds**
The licensee has failed to ensure the staffing mix was consistent with the residents assessed care and safety needs when the residents did not receive care according to their assessed needs.

**Rationale and Summary**

There were several complaints that staffing shortages resulted in residents not receiving their scheduled baths, continence care, two staff assist with transfers, and falls prevention interventions according to their assessed needs. Registered nursing staff, PSWs and family members reported they were concerned the residents were not receiving proper care, and there were delays in residents care, including missed and delayed medication, treatment, wound care administration due to the limited amount of time and staff to provide the residents' care.

Non-compliance was identified within this report regarding staffing shortages:

-FLTCA, 2021, s. 6 (7) regarding wound care for residents #012 and resident #013 was not provided, as scheduled in the plan of care.

-O. Reg. 246/22, s. 40 regarding improper transferring of resident #007.

-O. Reg. 246/22, s. 56 (2)(g) regarding delayed continence care for resident #007.

- FLTCA, 2021, s. 6 (9) 1 regarding resident #014's bathing documentation not being completed.

The DRC acknowledged the staffing schedule changed daily and there were shifts when the staffing levels were below the staffing complement.

The licensee has not been able to recruit and retain staff according to the licensee's staffing plan. Staffing shortages could potentially affect the wellbeing of all residents residing in the home. Failure to evaluate resident care needs on each shift when there were staffing shortages resulted in residents not receiving wound care treatments, continence care and delays in call bell response times,

**Sources:** Several residents' clinical health records, Staffing Schedules, and interviews with PSWs, RPNs, RNs, HAMs, and the DRC.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #010**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #010**
**Related to Compliance Order CO #007**

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:**
Prior non-compliance with O. Reg. 246/22, s. 35 (3) (a)
- CO was issued on April 15, 2024, in inspection #2024-1419-0001.
- WN was issued on November 24, 2023, in inspection #2023-1419-0003.

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 #008 Continence care and bowel

## management

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)**

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

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

Specifically, the licensee shall:

1. Within two weeks of receipt of this CO the HAM or designated registered staff is to conduct daily audits for a period of two weeks to ensure residents #007 has received continence care, as specified in the plan. Audit resident #007 to ensure their call bell has been answered in a timely manner and that their continence care needs have been met, as required based on the resident's assessed needs.

2. Audits are to include the name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

**Grounds**

The licensee has failed to ensure that resident #007 who required continence care received sufficient products changes to remain clean, dry, and comfortable.

**Rationale and Summary**

Complaints were submitted to the Director regarding the residents' care needs not being met due to staffing deficiencies and continence care not being provided in a timely manner.

A resident reported there were times when they would activate their call bell for continence care and the staff did not respond in a reasonable amount of time. They further indicated their skin would often become red and sore when they did not receive sufficient brief changes.

The resident's call bell audit confirmed the resident activated their call bell on several occasions and there were delays greater than seventeen minutes in staff response time. The staffing schedules confirmed there were PSW staffing shortages when the resident's request for continence care was delayed due to staff not being available to meet the resident's care needs.

The resident reported ongoing skin issues and insufficient products, a delay in continence care could result in worsening of the resident's skin condition.

**Sources:** the resident's clinical health records, licensee records and interviews with the resident, staff, and HAM #114.

**This order must be complied with by** December 20, 2024

## COMPLIANCE ORDER CO #009 Infection prevention and control program

NC #026 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 provide the inspector a copy of the signs posted throughout 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.

2. 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.

3. The IPAC Lead or designate is to provide in-person education to all housekeeping, and registered staff including agency, that worked on Creekside A during the month of September 2024. The education is to include:

a) Education on the appropriate selection, application, removal, and disposal of PPE.

b) Staff then returning and demonstrating their understanding on choosing the appropriate selection, application, removal, and disposal of PPE to the IPAC lead.

c) Keep a documented record of the return demonstration including the name of staff, date of training and return demonstration, outcome of demonstration, and education provided as feedback.

**Grounds**

1) The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated September 2023, section 9.1 directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, specifically 9.1 (d) referring to proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal for additional precautions.

**Rationale and Summary**

Staff were required to apply personal protective equipment (PPE) when providing direct care to two residents. A PSW was observed incorrectly removing their gown and gloves. The PSW acknowledged their technique for removing their PPE was not according to how they had been trained.

The IPAC lead indicated when staff remove their PPE they are to remove it separately by removing their gloves, gown, perform hand hygiene, goggles, mask perform hand hygiene. The IPAC lead acknowledged staff should not be taking off their gown and gloves together.

There was a risk of transmission of infectious agents when staff did not apply and remove PPE correctly.

**Sources:** Observations, an interview with the PSW and the IPAC lead's #109 and #111.

2) According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated September 2023, section 11.6 directed the licensee to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, specifically 11.6 referring to post signage at entrances and 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.

**Rationale and Summary**

During a tour of the home, there were no observed signs posted 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 is suspected or confirmed in any individual. The IPAC lead #010 was aware of the inspector's observation. Later that same day IPAC lead #010 reported the signs were posted.

September 18, 2024, a second observation was made of the signs posted. The signs posted were the COVID-19 screening tool for long-term care homes, dated August 31, 2022. The signs posted did not include the steps that must be taken if an infectious disease is suspected or confirmed in any individual.

In an interview with the IPAC lead #109 agreed the signs posted were the COVID-19 screening tool for long term care homes, dated August 31, 2022, and the signs did not include the steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Resident may have been at an increased risk for infectious disease when signs were

not posted to 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.

**Sources:** Observations, interviews with the IPAC leads.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #011**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #011**
**Related to Compliance Order CO #009**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, 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:**

Prior non-compliance with O. Reg. 246/22, s. 102 (2) (b)
-CO, AMP #004 for $5,500.00 issued on April 15, 2024, in inspection #2024-1419-0001
-WN issued on November 24, 2023, in inspection #2023-1419-0003.

-WN issued on April 5, 2023, in inspection #2023-1419-0002.
-CO issued on November 3, 2022, in inspection #2022-1419-0001.

This is the second 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 #010 CMOH and MOH

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

**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 is to conduct an audit of all Hand sanitizer dispensers where the Purell Alcohol based hand rub (AHBR) expiry date is not visible on the outside of the

dispenser. The audit is to include the location of the dispenser, the date the AHBR is expiring, and any deficiencies found. The audits completed are to be documented, the record kept and immediately made available to the inspector.

2. The IPAC lead is to develop and implement a process to ensure that all Alcohol Based Hand Rub (AHBR) dispensers in the home is not expired. The IPAC lead is to document the process developed and implemented and provide the documentation immediately upon request to the inspector.

**Grounds**
The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home, specifically ensuring that the Alcohol based hand rub was not expired.

As directed by: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings April 2024, stating that Alcohol Hand rub is not to be expired.

**Rationale and Summary**

During a tour of the home, it was observed there were two Alcohol Based Hand Rub (ABHR) that were expired.

The housekeeper confirmed the ABHR was expired and reported the housekeeping staff was responsible to check they had not expired.

Failing to ensure that the homes ABHR was not expired, increases the potential for

spread of infection at the home.

**Sources:** Observations and interview with staff.

**This order must be complied with by** December 20, 2024

**An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #012**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #012**
**Related to Compliance Order CO #010**

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:**
Prior non-compliance with O. Reg. 246/22, s. 272
-CO issued on November 3, 2022, in inspection #2022-1419-0001.

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.

## 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.