Ontario

Ministry of Long-Term Care

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

Order of the Director

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

Order of the Director Public Report Cover Sheet

Date of the Order: January 9, 2025	
Director Order Number: DO #001	
Inspection Number:	
Order Type: Order requiring management s. 157 (1)	
Licensee: St. Joseph's at Fleming	
Long Term Care Home and City: St. Joseph's at Fleming, Peterborough	
Issued By Brad Robinson (474)	**Director Digital Signature**

ORDER OF THE DIRECTOR SUMMARY

The Director has reasonable grounds to believe that the licensee cannot or will not properly manage the home, or cannot do so without assistance. In addition, the Director has taken into account the factors under section 347(1) of the O. Reg 246/22 (e.g. severity of the non-compliance, scope of the non-compliance and the licensee's history of non-compliance) in determining that this order is warranted.

Order of the Director Public Report

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Background

St. Joseph's at Fleming is a long-term care home ("the home") in Peterborough, Ontario. Operated by St. Joseph's at Fleming ("the licensee"), the home is licensed for 200 long-stay beds.

As a result of inspections conducted at the home between November 2022 to December 2024, several written notifications of non-compliance and compliance orders have been issued to the licensee for failing to comply with requirements

under the Fixing Long-Term Care Act, 2021 ("FLTCA") and Ontario Regulation 246/22 under the FLTCA ("O. Reg. 246/22").

Despite these findings and orders, the licensee has not taken the necessary actions to bring itself into compliance and sustain compliance. The licensee has demonstrated a lack of ability and understanding of what is required to address non-compliance, sustain it, and operate the home in a manner that meets the requirements of the FLTCA and O. Reg. 246/22.

Subsection 157(1) of the FLTCA states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to act as managers of the home or to assist in managing the home. Subsection 157(2) sets out that the Director may require the licensee to retain a manager to, (a) manage or assist in managing the entire operations of the long-term care home; or (b) manage or assist in managing a specific issue related to the operation of the long-term care home. Subsection 157(3) sets out the possible grounds for issuing such an order.

As set out below, I am ordering the licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to act as managers of the long-term care home (to manage the entire operations of the home). Pursuant to s. 157(3)(a) and (b) of the FLTCA, I am issuing this order as the licensee has not complied with several requirements under the FLTCA and O. Reg. 246/22 and as explained further in the grounds of the order, I have reasonable grounds to believe that the licensee cannot or will not properly manage the home or cannot do so without assistance.

As the grounds below establish, there have been significant and, in some cases, repeated non-compliance with the same requirements under the FLTCA and O. Reg. 246/22. As a result, various compliance action has been taken against the licensee in attempts to bring the home into compliance, including multiple written

notifications, compliance orders and administrative penalties. Further, on May 2, 2024, pursuant to subsection 56(1) for the FLTCA, I directed the placement co-ordinator to cease authorizing admissions to the home on the belief that there was a risk of harm to the health or well-being of residents of the home or persons who might be admitted as residents.

Beginning May 14, 2024, inspection managers of the ministry's Inspection Branch have held regular meetings with the licensee and its board of directors to discuss the compliance concerns and the licensee's actions to be taken to ensure compliance. Despite the regular communication, the licensee has not taken the necessary actions to address and correct the ongoing issues of non-compliance at the home.

Further, there has been instability in senior leadership as there has been frequent turnover in leadership/management positions at the home as well as the corporate level through the resignation of the licensee's board of directors. This instability has not ensured the effective management of the operations of the home and an ability for the licensee to effectively implement and sustain corrective actions to ensure compliance.

The licensee's recurring non-compliance with various requirements, including but not limited to, protecting residents from abuse and/or neglect (s. 24 of FLTCA) and complying with skin and would care (s. 55, O. Reg. 246/22) and infection protection and control requirements (s. 102, O. Reg. 246/22) directly impacts resident care and safety, as non-compliance with these requirements poses a risk of harm to residents of the home, such as, protecting residents from sexual abuse (s. 24 of FLTCA), ensuring staff follow the licensee's pain and wound policies leading to transfer of resident to hospital, resulting from breakdown in skin integrity (s. 24 of FLTCA), inappropriately placing residents at increased risk of spread of infection within the home resulting from the inappropriate utilization of personal protective equipment

(PPE) and PPE stations to be fully stocked (s. 102, O. Reg. 246/22).

A statistical analysis of the home's performance showed that:
-The home received 98 complaints during the last 24 months and registered a total of 216 critical incident system reports with the Ministry of Long-Term Care.
-During inspection, the home was issued 112 non-compliances.

Collectively, these reasons have provided me, the Director, with reasonable grounds to believe that the licensee cannot or will not properly manage the home, or cannot do so without assistance, and thus must be ordered to retain a manager to manage the entire operations of the home.

I have taken into account the factors under subsection 347(1) of O. Reg 246/22 (e.g., severity of the non-compliance, scope of the non-compliance and the licensee's history of non-compliance) in determining that this order is warranted.

Order: DO #001

To St. Joseph's at Fleming, you are hereby required to comply with the following order by the date(s) set out below:

Pursuant to

Order pursuant to FLTCA, 2021, s. 157 (1)
Non-compliance with: FLTCA, 2021, s. 157 (1)
Order requiring management
s. 157 (1) The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to act as managers of the long-term care home or to assist in managing the long-term care home.

Order

St. Joseph's at Fleming, ('the licensee') is ordered:
(a) To retain one or more persons, at your expense, described in paragraph (c) or (d)

of this Order, to manage the entire operations of St. Joseph's at Fleming, located at 659 Brealey Drive Peterborough, Ontario;

(b) To submit to the Director, Capital Planning Branch, within 14 calendar days of being served with this Order, a proposed person(s) described in paragraph (a) to this Order;

(c) The person(s) described in paragraph (a) to this Order must be acceptable to the Director, Capital Planning Branch and approved by the Director, Capital Planning Branch, in writing;

(d) If the licensee does not submit a proposed person(s) described in paragraph (a) to this Order to the Director, Capital Planning Branch within the time period specified in paragraph (b) to this Order, the Director, Capital Planning Branch will select the person(s) that the licensee must retain to manage the home;

(e) The person(s) described in paragraph (a) to this Order acceptable to the Director, Capital Planning Branch, will have specific qualifications, including:

(i) The experience, skills and expertise required to operate and manage a long-term care ("LTC") home in Ontario and to maintain compliance with the FLTCA and O. Reg. 246/22 under the FLTCA;

(ii) Have a good compliance record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides consulting services has a compliance record under the FLTCA and/or Long-Term Care Homes Act, 2007 that is considered to be substantially compliant, including:

(1) Critical incidents that occur are reported as required;

(2) Complaints are managed effectively in the LTC home;

(3) The LTC home develops policies/procedures using evidenced-based practice and quality strategies;

(4) The LTC home responds to issues identified during inspections; and

(5) Non-compliance in areas of actual harm or high risk of harm to residents and any other persons identified during inspections are rectified within the time frame required by the inspector;

(iii) Demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this Order,

(1) Been declared bankrupt or made a voluntary assignment in bankruptcy;

(2) Made a proposal under any legislation relating to bankruptcy or insolvency; or

(3) Have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets;

(f) To submit to the Director, Capital Planning Branch, a written contract pursuant to section 113 of the FLTCA within 14 calendar days of receiving approval of the Director, Capital Planning Branch pursuant to paragraph (c) of this Order or the selection of a person(s) pursuant to paragraph (d) of this Order;

(g) To execute the written contract within 24 hours of receiving approval of the written contract from the Director, Capital Planning Branch, pursuant to section 113 of the FLTCA and to deliver a copy of that contract once executed to the Director, Capital Planning Branch;

(h) To submit to the Director, Long-Term Care Inspections Branch, a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the home and that specifically addresses strategies and actions to achieve compliance with those areas identified as being in non-compliance within 30 calendar days of receiving approval of the Director, Capital Planning Branch, pursuant to paragraph (c) of this Order or the selection of a person pursuant to paragraph (d) of this Order;

(i) The person approved by the Director, Capital Planning Branch pursuant to paragraph (c) to this Order or selected by the Director, Capital Planning Branch pursuant to paragraph (d) of this Order, shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order within 24 hours of the execution of that written contract;

(j) The management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director;

(k) Any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order; and

(l) Upon being served with this Order, comply with paragraphs (a) to (k) and not take any actions that undermine or jeopardize the ability for the person approved by the Director, Capital Planning Branch pursuant to paragraph (c) to this Order or selected by the Director, Capital Planning Branch pursuant to paragraph (d) of this Order to manage the home to its full extent.

Grounds

The licensee's non-compliance

Over approximately a two-year period (November 2022 to December 2024), the licensee has not complied with several requirements under the FLTCA, O. Reg. 246/22 under the FLTCA. The licensee has been issued 72 written notifications (WNs), 40 compliance orders (COs) and 26 administrative penalties (AMPs) (totaling over $100,000) over the last two years (November 2022 to December 2024).

This Order relies on all inspection reports, non-compliance findings, orders and administrative penalties issued from the following inspections conducted at the home:

Inspection Number - Date Inspection Report(s) Issued
2022-1419-0001 - November 3, 2022
2023-1419-0002 - April 5, 2023
2023-1419-0003 - November 24, 2023, January 3, 2024 (A1)
2024-1419-0001 - April 15, 2024
2024-1419-0002 - October 21, 2024
2024-1419-0003 - December 9, 2024
2024-1419-0004 - December 31, 2024

Based on these inspections, below is a summary of a few of the significant and recurring areas of the licensee's non-compliance under the FLTCA and O. Reg. 246/22 that have posed a risk of harm and risk to the well-being of residents in the home.

Prevention of Abuse and Neglect (s. 24 of the FLTCA)
Inspections (2023-1419-0002, 2023-1419-0003, 2024-1419-0001 and 2024-1419-

0002) have established the licensee's recurring non-compliance with s. 24(1) of the FLTCA. During these inspections, inspectors made observations, conducted interviews, and collected records. In doing so, the inspectors established that the licensee's staff and/or area managers failed to protect specific residents from abuse by anyone and/or ensure residents were not neglected by the licensee or staff (contrary to s. 24(1) of the FLTCA)).

-During inspection 2023-1419-0002, the licensee had failed to comply with previously issued CO related to protecting residents pursuant to s. 24(1) of the FLTCA, resulting in the issuance of a WN and $1,100 AMP.
-During inspection 2023-1419-0003, the licensee had also failed to comply with previously issued compliance orders related to protecting residents pursuant to s. 24(1) of the FLTCA, resulting in the issuance of a WN and AMP of $2,200. In addition, inspectors issued new findings of non-compliance with s. 24(1) of the FLTCA, which resulted in the issuance of an additional compliance order and $5,500 AMP.
-During inspection 2024-1419-0001, the licensee had failed to comply with s. 24(1) of FLTCA resulting in the issuance of a compliance order and an associated $11,000 AMP, and;
-During inspection 2024-1419-0002, the licensee had failed to comply with the previously issued compliance order related to Duty to Protect from inspection 2024-1419-0001, resulting in a written notification for failure to comply with a compliance order and associated AMP of $1,100. In addition, inspectors established further non-compliance with the Duty to Protect, resulting in a Compliance Order and associated AMP of $16,500 as this was a third non-compliance under clause 349(6)(b) of O. Reg. 246/22.

During these four inspections within the past two years, inspectors identified continued, and in some instances, repeated non-compliance related to Duty to Protect, including but not limited to;
-Failure to ensure a resident call bell was within reach, and leaving a resident on the

toilet with no access to a call bell and in the dark,
-Failure of multiple staff to follow the licensee's skin and wound polices and failure of the licensee to protect a resident from sexual abuse, and
-Failure of staff to collaborate with each other, the physician/Nurse Practitioner and the Substitute Decision Maker,
-Failure to complete appropriate assessments of a resident when the resident displayed signs and symptoms of respiratory distress, neglectful inaction which caused harm to the resident.

A total of three written notifications (all associated with Failures to Comply with previously issued compliance orders), three compliance orders and six AMPs totaling $37,400 were issued to the Licensee.

Skin and Wound Care
Inspections (2024-1419-0001 and 2024-1419-0002) have demonstrated continued non-compliance with O. Reg 246/22, s. 55 (2) (a) (ii) and 55 (2) (b) (i) resulting in the issuance of three written notifications and one high priority compliance order.

The licensee failed to:
-Ensure when multiple residents exhibited areas of altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment,
-Ensure that the assessment of a resident's pressure wounds were documented using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, and;
-Ensure a resident received a skin assessment upon return from the hospital.

Infection Prevention and Control (IPAC)
Inspections 2022-1419-0001, 2023-1419-0002, 2023-1419-0003, 2024-1419-0001

and 2024-1419-0002 have demonstrated continued and repeated non-compliance with O. Reg 246/22 S. 102(2) b, s. 102 (4)(b), s. 102 (4)(d), s. 102 (7)9, s. 102 (8) and s. 102(9)a.
-During inspection 2022-1419-0001, a compliance order was issued for non-compliance with O. Reg 246/22 s. 102 (2) b for the licensee's failure to implement the IPAC standard.
-A second compliance order and associated $5,500 AMP were issued under s. 102 (8) for failing to ensure that all staff participate in the implementation of the home's IPAC program.

-Licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed, specifically, in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units issued by the Director, stated that homes must provide all health care workers, other staff, and any visitors who are required to wear personal protective equipment (PPE) with information and training on the care, safe use, maintenance, and limitations of that PPE, including training on proper donning and doffing.

-During inspection 2023-1419-0002, two written notifications were issued related to IPAC:

-One WN for O. Reg 246/22 s. 102 (2) b for the licensee's failure to implement the IPAC standard, and;

-One WN for Failure to Comply with an Order related to O. Reg 246/22 s. 102 (9)(a) for the licensee's failure to monitor symptoms indicating the presence of infection in residents in accordance with the IPAC standard issued under s. 102(2)) and associated $1,100 AMP.

-During inspection 2023-1419-0003, four written notifications were issued related to IPAC:

-One WN for O. Reg 246/22 s.102 (2) b for the licensee's failure to implement the IPAC standard;

-One WN for O. Reg 246/22 s.102 (8) for failing to ensure that all staff participate in the implementation of the home's IPAC program;

-Failure to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program related to routine cleaning and disinfection of resident's mobility equipment;

-One WN for O. Reg 246/22 s. 102 (9)(a) for the licensee's failure to monitor symptoms indicating the presence of infection in residents in accordance with the IPAC standard issued under s. 102(2)); and

-One WN for Failure to Comply with an Order related to O. Reg 246/22 s. 102 (9) a and associated $2,200 AMP marking the second consecutive failure to comply with this Compliance Order from inspection 2022-1419-0001.

-During inspection 2024-1419-0001, two written notifications and four compliance orders as well as associated AMPs, were issued related to IPAC:

-One WN for O. Reg 246/22 s.102 (4) (b) for failing to ensure that an interdisciplinary IPAC team that includes the IPAC lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator coordinates and implements the program;

-One WN for O. Reg 246/22 s.102 (4) (d) for failing to ensure that the local medical officer of health (or designate) is invited to the meetings of the interdisciplinary IPAC team;

-One CO for O. Reg 246/22 s. 102 (2) (b) for the licensee's failure to implement the IPAC standard;

-Associated $5,500 AMP

-One CO for O. Reg 246/22 s. 102 (7) 9 for failing to ensure that the designated IPAC lead reviews any daily and monthly screening results collected by the licensee to determine whether any action is required.

-One CO for O. Reg 246/22 s. 102 (8) for failing to ensure that all staff participate in the implementation of the home's IPAC program, such as, but not limited to;

-Staff carrying soiled incontinence products and linens throughout the hallway, vital signs machines and mechanical lifts being used between residents without cleaning and/or disinfection, as well as, soiled gloves, incontinent products and linens left on floors in common spa rooms and resident bedrooms.

-Associated $11,000 AMP

-One CO for O. Reg 246/22 s. 102 (9) (a) for the licensee's failure to monitor symptoms indicating the presence of infection in residents in accordance with the IPAC standard issued under s. 102(2))

-Associated $5,500 AMP

-During inspection 2024-1419-0002, one compliance order and an $11,000 AMP was issued related to IPAC, O. Reg 246/22 s. 102 (2) (b) for failure to comply with the IPAC standard.

During the five identified inspections over the past two years, inspectors identified continued and, in some instances, repeated non-compliance related to IPAC. A total of eight written notifications (two associated with Failures to Comply with previously issued compliance orders), seven compliance orders and seven AMPs totaling $41,800 were issued to the Licensee. Residents of LTC homes are particularly susceptible to severe illness from infection. The staff's non-participation in the implementation of the IPAC program, and the

ongoing lack non-adherence to IPAC regulations and standards put residents at increased risk of infection.

November 2024 inspection (#2024-1419-0003)

New findings of non-compliance were made during a complaint / critical incident inspection completed in November 2024. The inspection resulted in the issuance of 13 written notifications, 4 compliance orders and 1 administrative monetary penalty.

The following compliance orders were issued to the licensee for non-compliance with various requirements under the FLTCA and O. Reg. 246/22:

-s. 147 (1) of O. Reg. 246/22: The licensee failed to ensure the Substitute Decision Maker (SDM) was notified of a medication incident involving the resident and the medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

-s. 25 (1) of FLTCA, 2021: The licensee failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with on two separate occasions.

-s. 6 (7) of FLTCA, 2021: The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

-Associated $3,300 AMP

In addition to the compliance orders issued above, the following written notifications were also issued to the licensee as a result of the November 2024 inspection:

-s. 112 (1) 4. ii. of O. Reg 246/22: The licensee failed to ensure a critical incident related to an alleged resident to resident physical abuse included the long-term actions planned to correct the situation and prevent recurrence.

-s. 6 (1) (c) of FLTCA, 2021: The licensee failed to ensure that the written plan of care for a resident, regarding transfer and mobility, provided clear directions to staff and others who provide direct care to the resident.

-s. 6 (5) of FLTCA, 2021: The licensee failed to ensure that a 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.

-s. 6 (5) of FLTCA, 2021: The licensee failed to ensure that a 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.

-s. 6 (9) 1 of FLTCA, 2021: The licensee failed to ensure the provision of the care set out in the plan of care for a resident was documented accurately.

-s. 18 (1) (a) of O. Reg 246/22: The licensee failed to ensure that where bed rails were used, residents were assessed and the resident's bed system was evaluated to minimize risk to the resident.

-s. 56 (2) (g) of O. Reg 246/22: The licensee failed to ensure seven residents who required continence care products, had sufficient changes to remain clean, dry and comfortable.

-s. 29 (3) 5 of O. Reg 246/22: The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

-s. 34 (1) 2 of O. Reg 246/22: The licensee failed to ensure that a resident's wheelchair was appropriate for the resident, as it was not based on the resident's current physical condition.

-s. 53 (1)1 of O. Reg 246/22: The licensee failed to ensure staff comply with the licensee's Fall's Prevention and Management Program policy that directs RN/RPNs to document a resident fall in the progress notes.

-s. 102 (2) (b) of O. Reg 246/22: The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, quarterly audits were not completed to ensure that audits were performed regularly to ensure that all staff can perform the IPAC skills required of their role, in accordance with IPAC Standard, Additional Requirement 7.3 (b) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

-s. 140 (1) of O. Reg 246/22: The licensee failed to ensure that no drug is administered to a resident unless the drug has been prescribed for the resident.

-s. 28 (1) of FLTCA, 2021: The licensee failed to ensure that an allegation of improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident was immediately reported to the Director.

-s. 53 (1) 4. Of O. Reg 246/22: The licensee failed to ensure staff complied with the licensee's Pain Management Program.

Leadership Instability

In the past two years, there has been frequent turnover in key leadership/management positions including:

-Four Home Area Managers in 2023 and 2024, most recent effective December 2024.

-Director of Care (DOC) replaced in August 2023

-Infection Prevention and Control Lead replaced September 2024

-Resignation of Board of Directors in November 2024

-Interim Board effective immediately

-CEO Resignation effective December 31, 2024

-Interim CEO put in place as of December 20, 2024.

The frequent vacancies and turnover in key leadership positions over a short period represents instability within the home at the management level. Management is responsible for leading and managing the operations of the home, including developing actions to address non-compliance.

The instability and turnover contribute to the inability for the senior leadership/management to provide effective direction to staff and expertise to effectively understand the compliance issues at the home, to take the necessary actions to correct them, and to manage/operate the home in accordance with the requirements of the FLTCA.

Since May 14, 2024, on 25 occasions, the Inspections Branch's District Manager and/or Inspection Manager of the Central East District Office have met with the licensee and licensee's board members to discuss inspection results as well as the licensee's plan to achieve compliance

with requirements. Despite these regular meetings, the licensee has not taken adequate action to ensure and sustain compliance with requirements.

In summary, the following provide me with reasonable grounds to believe that the licensee cannot or will not properly manage the LTC home, or cannot do so without assistance:

-The licensee's repeated non-compliance with requirements under the FLTCA and O. Reg. 246/22 as set out above and in inspection reports 2022-1419-0001, 2023-1419-0002, 2023-1419-0003, 2024-1419-0001, 2024-1419-0002, 2024-1419-0003

-In particular, the licensee's repeated instances of non-compliance with s. 24 of the FLTCA (duty to protect residents), s. 102 of O. Reg. 246/22 (IPAC requirements), provisions relating to direct resident care, including s. 6 of the FLTCA (plan of care), s. 55 of O. Reg. 246/22 (wound and skin care) and s. 140 of O. Reg. 246/22 (administration of drugs) noted above. The licensee's non-compliance with these requirements poses a risk of harm (and risk to the well-being) of residents of the home, as multiple care areas of residents have been affected.

-The leadership instability of the licensee and home through frequent turnover in leadership positions has not enabled the licensee to effectively understand, initiate and address compliance issues at the LTC home and manage the operations of the home.

-My existing direction in place since May 2, 2024 that ceased admissions to the home. This direction was issued pursuant to subsection 56(1) for the FLTCA on my belief that there was a risk of harm to the health or well-being of residents of the home or persons who might be admitted as residents. Since the direction was issued, the licensee has not been able to come into compliance

with requirements as demonstrated by the most recent inspection conducted at the home (2024-1419-0003).

When taking all of the above into account, there are reasonable grounds to believe that the licensee cannot or will not properly manage the home without assistance.

The decision to issue this order is based on the scope and severity of non-compliance, and the licensee's compliance history in accordance with s. 347(1) of the O. Reg. 246/22 over the past 36 months.

The scope of non-compliance is identified as widespread in the home and represents a systemic failure that affects or has the potential to negatively affect many, if not all, of the home's residents. The severity of the non-compliance is determined to be high based on there being both harm and risk of harm to residents caused by the licensee's non-compliance as identified in the past inspections. As noted above, since October 2022, the licensee has a history of non-compliance, and, in some cases, repeated non-compliance with several requirements under the FLTCA and O. Reg. 246/22, which makes this order warranted.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

Pursuant to s. 170 of the Fixing Long-term Care Act, 2021 the licensee has the right to appeal any of the following to Health Service Appeal Review Board (HSARB):

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
email:
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.