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

Hamilton District
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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 31, 2024

Inspection Number: 2024-1422-0004

Inspection Type:
Critical Incident
Follow up

Licensee: Maryban Holdings Ltd.

Long Term Care Home and City: Billings Court Manor, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 2-4, October 7-10, 2024.

The following intakes were inspected:

- Intake #00121866 -Follow-up #1 - Compliance Order #001/2024_1422_0003, FLTCA, 2021 - s. 6 (7) Plan of care. CDD September 20, 2024.
- Intake #00114314/CI#2938-000022-24 was related to prevention of abuse and neglect.
- Intake #00115423/CI#2938-000030-24 was related to prevention of abuse and neglect.
- Intake #00121219/CI#2938-000042-24 was related to prevention of abuse and neglect.
- Intake #00121874/CI#2938-000045-24 was related injury of unknown causes.
- Intake #00122245/CI#2938-000047-24 was related to infection prevention and control.

The following intake were completed in this inspection: Intake #00120295/CI#2938-000039-24 was related to infection prevention and control.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1422-0003 related to FLTCA, 2021, s. 6 (7) inspected by an inspector.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed, and the plan was no longer necessary.

Rationale and Summary

During a record review of the plan of care, a resident's specified intervention did not identify the frequency of action required for care. It was brought to the attention of staff on an identified date. On a later date, the intervention was updated in the care plan as resolved.

During a follow up interview with the staff, they stated that the intervention was resolved because it was no longer used for the resident and had not been used for a few months.

Prior to the conclusion of the inspection, the plan of care was updated and intervention was resolved.

Sources: plan of care, interview with staff.

Date Remedy Implemented: October 8, 2024

WRITTEN NOTIFICATION: Resident Bill of rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that they respected a resident's right to have their lifestyle and choices respected.

Rationale and Summary
During a record review, a resident's progress notes and the incident investigation notes indicated that there was physical altercation between an identified staff and that resident. The resident's plan of care stated to approach at a later time if care refused at first.

On a specified date, while an identified staff was providing care to the resident and the resident exhibited a responsive behaviour, the identified staff remained with the resident, and did not follow the required approach to care.

During an interview with the administrator, they acknowledged that the identified staff did not respect the resident's rights by not respecting the resident's choices.

By not respecting the resident's choice and restricting the resident, there was potential to put the resident's safety at risk.

Sources: Critical incident (CI), home's investigation notes, progress notes, Interview

with staff, Zero Tolerance of Resident Abuse Policy.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's plan of care indicated that they required two staff for Activities of Daily Living (ADLs). Their plan of care also indicated they were a high risk for falls.

On an identified date, a staff member completed an ADL for a resident on their own.

Failure to ensure that care was provided with two staff as per the resident's plan of care, put the resident's safety and well-being at risk.

Sources: Observations, interviews, and resident's plan of care.

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure resident #002 and #003's call bells could be easily accessed and used at all times.

Rationale and Summary
A) On an identified date in October 2024, it was noted that resident #002 did not have their call bell within their reach and the call bell was not positioned as identified in the resident's plan of care.

When asked how the resident would obtain staff help when needed, they stated they would call out when they saw someone walking by their room.

Failure to ensure that resident #002's call bell could be easily accessed and used at all times placed them at risk for not receiving help when needed.

Sources: Resident #002's care plan and interview, and observations.

Rationale and Summary
B) On an identified date in October 2024, resident #003 called out from their room to ask for help and asked where their call bell was located when staff entered the room.

Resident #003's care plan indicated that their call bell was to be within their reach while they were in bed. The inspector identified that the call bell was not within reach as care planned.

Failure to ensure that resident #003's call bell could be easily accessed and used at all times led to the resident calling out for help when they needed it.

Sources: Resident #003's care plan, observations, and interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 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
The home received an allegation that on a specified date, an identified staff member transferred a resident using a mechanical lift without the aid of a second staff member. The home conducted an investigation and confirmed that the identified staff member transferred a resident using the mechanical lift by themselves.

The home confirmed that when performing a transfer by mechanical lift, there should be two staff present.

Failure to ensure that safe transferring techniques were used when assisting a resident put their safety at risk.

Sources: CI, the home's investigation notes, interviews with staff and the Administrator.

WRITTEN NOTIFICATION: Dress

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that a resident was assisted with getting dressed in keeping with the resident's preferences, in their own clean clothing.

Rationale and Summary
On an identified date in 2024, a resident requested to pick out clothing they wished to wear, however staff did not provide this choice. The home's investigative notes indicated that a staff member did not respect the resident's clothing choices and preferences, and that it had a negative impact on the resident's emotional state.

Sources: Interview with resident and the Administrator, the home's investigation notes.

WRITTEN NOTIFICATION: Responsive behaviour

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that assessments and documentations were completed for a resident when they demonstrated a responsive behaviour.

Rationale and Summary
The home policy states that the home uses the Dementia Observation System (DOS) to document observed behaviour over time, which allows for a thorough evaluation of any patterns of behaviour identified thus facilitating a comprehensive care plan.

On an identified date in April 2024, there was an incident where a resident exhibited a responsive behaviour. During a review of the resident's DOS records, DOS records on several identified dates were not fully completed as required.

During an interview with staff, they stated that DOS charting should be completed on every shift, and that it was not completed on multiple shifts for the resident.

By not completing DOS charting, it did not allow for a thorough evaluation of any pattern of identifiable behaviours to enable the facilitation of a comprehensive care plan for the resident.

Sources: reviewed progress notes, Care plan, Abuse Policy, Assessments, interview with staff.

WRITTEN NOTIFICATION: Emergency Plans, CMOH and MOH

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

During a confirmed COVID-19 outbreak on the two home areas on identified dates between July and August 2024, the licensee failed to ensure that all applicable recommendations made by the Chief Medical Officer of Health (CMOH) were followed in the home. Specifically, high touch surfaces throughout all common areas accessed by residents were not cleaned and disinfected at minimum twice daily on specified dates during an outbreak.

As of April 19, 2024, the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, section 3.12 for enhanced environmental cleaning and disinfection, recommended the minimum twice daily cleaning and disinfecting of high touch surfaces for common areas, treatment areas, dining areas and lounge areas.

Rationale and Summary
The frequency of cleaning was identified in the home's housekeeping policies and procedures, as well as confirmed by the home's Operations Manager of Housekeeping (OMH), IPAC lead, and housekeeping staff. All high touch surfaces throughout the unit were to be cleaned and disinfected at least twice daily. Staff

identified that during an outbreak, including COVID-19 outbreaks, high touch surfaces would be disinfected again by housekeeping or additional Personal Support Workers (PSW) later in the shift or in the evening.

The MLTC Inspector did not find high touch surface cleaning and disinfection documentation for multiple identified dates and times during the outbreak period.

The IPAC Lead and OMH acknowledged that the expectation for documentation was to confirm that the task of cleaning and disinfecting high touch surfaces was completed. Due to the missing information on the identified dates, staff could not establish that high touch surfaces were cleaned at the required frequency.

There was a potential of disease transmission during the home's COVID-19 outbreak when the home failed to implement their procedures and CMOH recommendations for twice daily cleaning and disinfecting of high touch surfaces.

Sources: Interviews with staff; high touch point surface cleaning records; housekeeping cleaning records; the home's housekeeping procedures; Critical Incident Report 2938-000047-24; Recommendations for Outbreak Prevention and Control in institutions and Congregate Living Settings, section 3.12 (page 35) dated April 2024.

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 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)]:
The licensee shall:
1) Conduct audits once per week of an identified staff member's behaviour and interactions with residents to ensure there is no abuse. Conduct these audits for a period of one month; and
2) Retain records of the audits conducted, including the dates and times they were done, who conducted them, the results of each audit and if any follow-up coaching or interventions were required, and if so, include what the coaching or intervention entailed.

Grounds
The licensee has failed to ensure that residents were not neglected by an identified staff member and that a resident was protected from abuse by the identified staff member.

Ontario Regulation (O. Reg.) 246/22 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

O. Reg., 246/22 defines "emotional abuse" as (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
A) The home received an allegation of neglect against an identified resident. Through the home's investigation it was found that on an identified date on a specified home area, the staff member neglected their job duties and failed to provide residents with their call bells. The home suspended the staff member and stated that their behaviour constituted neglect.

Failure to ensure that residents' on the home area were not neglected, put their safety and well-being at risk.

Sources: CI: 2938-000042-24, the home's investigation notes, interview with the Administrator.

Rationale and Summary
B) The home received an allegation of abuse against an identified staff member. The home placed the staff member on suspension pending their investigation.

Through the home's investigation, they substantiated that the identified staff member emotionally abused a resident when they demonstrated threatening and intimidating behaviour that caused the resident to be fearful. During the inspection, the resident informed the Inspector that they recalled the identified staff member being angry and mean toward them.

The resident's safety and well-being were impacted when they were not protected from emotional abuse by the identified staff member.

Sources: CI: 2938-000042-24, the home's investigation notes, interviews with resident and the Administrator.

This order must be complied with by December 30, 2024

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

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

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:

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 Policy to promote zero tolerance

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Provide education for an identified staff member, and the home's management team, on their policy to promote zero tolerance, specifically including assessments to be completed; and
2) Document and retain records of the above education including the date and who provided the education.

Grounds
The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents had been complied with.

Rationale and Summary

A) On an identified date, there was an allegation of abuse and neglect against a staff member toward a resident that had occurred on an earlier date. The home investigated and substantiated emotional abuse. As part of the home's Zero Tolerance of Resident Abuse and Neglect policy, all staff were responsible to ensure the safety of and provide support to the abuse victim(s), through completion of full assessments, a determination of resident needs, and a documented plan to meet those needs.

The resident's clinical records were reviewed and there were no assessments or documentation to indicate that the resident had assessments completed. The Administrator confirmed that the resident was not assessed and agreed that after the home was notified of the allegations, the resident should have been assessed.

Failure to ensure the home's Zero Tolerance of Abuse and Neglect policy was complied with, had risk for potential resident health changes to not be identified.

Sources: Resident clinical record, the home's policy titled Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, last reviewed February 2024, and interview with the Administrator.

Rationale and Summary

B) On an identified date, there was a physical altercation between a staff member and a resident. As per the home's Zero Tolerance of Resident Abuse Policy, and interviews with staff; a head-to-toe assessment is required after such an occurrence. The policy states to ensure the safety of and provide support to the abuse victims, through completion of a full assessment, a determination of the resident needs and a documented plan to meet those needs. During the record review there was no head to toe assessment documented for the resident on the day of the incident.

During an interview with the Administrator, they acknowledged that a head-to-toe assessment should be done immediately, and it would be documented under the assessment tab in Point Click Care (PCC). The staff responsible to assess the resident acknowledged during an interview, that they did not complete the appropriate documentation for the resident's assessment on the day of the incident.

By not completing a head-to-toe assessment for the resident, the home's process of ensuring the resident's safety was not followed.

Sources: CI, home's investigation notes, progress notes, Interview with staff, Zero Tolerance of Resident Abuse Policy.

This order must be complied with by December 30, 2024

COMPLIANCE ORDER CO #003 Reporting certain matters to Director

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

The licensee shall:
1) Re-educate all active agency staff to ensure they understand the home's process for reporting incidents of abuse and/or neglect; and
2) Retain records of the education provided, the content of the education, who attended the education, the date it was held, staff signatures indicating they attended, and who provided the education.

Grounds
The licensee has failed to ensure that suspected or alleged abuse and/or neglect of several residents was immediately reported to the Director.

Rationale and Summary
The home received an email from a staff member on an identified date, alleging abuse and neglect of multiple residents by another staff member from four days prior. The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) on the same day they were notified of the allegations and suspended the suspected staff member pending their investigation.

The Administrator acknowledged that staff should have reported the allegations immediately to either the RN on duty or the manager on call, who then would have reported to the MLTC Director. As a result of reporting the incident late, the suspected staff continued to work until the home was aware of the allegation and put residents at risk of further abuse and neglect.

Failure to ensure that an incident of alleged abuse and neglect was immediately reported to the Director, put residents at risk of further harm or abuse.

Sources: CI: 2938-000042-24, the home's investigation notes, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy, last reviewed

February 2024, interview with the Administrator.

This order must be complied with by December 30, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #012 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)]:
The licensee shall:
1) Educate the identified staff member on the home's additional precautions and personal protective equipment (PPE) policies, including but not limited to proper selection of PPE for contact precaution rooms; and
2) Document and maintain a written record of the education provided, including the date(s) it was held, the staff member in attendance, the staff member who provided the education, and the staff's signature that they understood the education; and
3) Conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the COVID-19 outbreaks associated with critical incident report 2938-000047-24. Document and maintain a written record of the debrief session, including but not limited to:
- the members who participated in the debrief session,
- the summary of findings,

- recommendations to the licensee for the outbreak management practices, if any, and,
- improvements and actions planned for the outbreak management practices of the home, if any.

Grounds

1) The licensee failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes September 2023" (IPAC Standard) was implemented.

Rationale and Summary

The IPAC Standard under section 9.1 (f) indicated that the licensee shall ensure staff follow additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal of PPE. The home's policy for PPE identified that PPE was to be donned prior to entering the resident's room and following the precaution signage.

The plan of care for a resident indicated that the resident was on additional contact precautions as related to their medical diagnosis. The door to the room of the resident identified that the resident was on contact precautions, requiring the use of a gown and gloves as PPE when providing direct care.

An identified staff member was observed in the room of the resident assisting with grooming and hygiene care while the resident was in bed. The identified staff member did not have gloves or a gown on during this time, until the identified staff member saw the inspector and donned gloves prior to continuing care.

The identified staff member acknowledged that they did not apply the correct PPE prior to entry and providing care for the resident as required. Registered staff and the IPAC Lead confirmed the expectation of all staff providing direct care to a

resident on contact precautions required the use of a gown and gloves as per the signage.

There was potential for an increased risk for spread of infection when the staff member did not don the appropriate PPE prior to providing resident care in an additional precautions room.

Sources: Observation; Interviews with staff; clinical record of resident; the home's policy titled "Personal Protective Equipment Policy" dated January 2024.

2) The licensee failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes September 2023" (IPAC Standard) was implemented.

Rationale and Summary
Under the IPAC Standard section 4.3, the licensee failed to ensure that following the resolution of the outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conducted a debrief session to assess IPAC practice effectiveness in the management of the outbreak. The OMT failed to summarize the findings of the outbreak and provide recommendations to the licensee for improvements to outbreak management practices.

Specifically, there were two COVID-19 outbreaks on two separate home areas during identified dates from July to August 2024. During that time, the OMT conducted regular meetings regarding the outbreak status.

Upon the outbreak being declared over on a specified date in August 2024 by the local public health unit, the IPAC lead acknowledged that the OMT did not conduct a debrief session and review of the data from the outbreak to make recommendations for improvements to their outbreak management practices. The

IPAC lead confirmed that this was an area that needed to be implemented.

There was a potential risk for ongoing transmission of infection when the homes outbreak control measures were not reviewed for effectiveness following the conclusion of their COVID-19 outbreak.

Sources: Critical Incident report 2938-000047-24; OMT meeting notes; the home's communication with public health; the home's policy "Outbreak Management Team" dated January 2024; observation of IPAC board; interview with IPAC lead coordinator.

This order must be complied with by December 30, 2024

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #004

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:

O. Reg. 246/22, s. 102 (2) (b) issued as a CO on July 6, 2022 from inspection #2022-1422-0001; same legislation issued as a CO on March 1, 2023 from inspection #2023-1422-0004

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.

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.