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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londondistrict.mltc@ontario.ca

Amended Public Report (A1)

Report Issue Date: January 26, 2023	
Inspection Number: 2022-1473-0002	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Henley Place Limited	
Long Term Care Home and City: Henley Place, London	
Lead Inspector Peter Hannaberg (721821)	**Lead Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2023.01.26 12:11:58 -05'00'
Additional Inspector(s) Debbie Warpula (577) Karen Honey (740899)	

AMENDMENT INSPECTION REPORT SUMMARY

This inspection report has been amended to reflect a revision in the grounds for the following orders, after completion of a Director Review and determination completed and served to the licensee January 19, 2023:

- *CO #002 from inspection #2022_1473_0002 relating to O.Reg. 246/22, s. 147 (1) (a).*
- *CO #003 from inspection #2022_1473_0002 relating to O.Reg. 246/22, s. 147 (1) (b).*

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 31, November 1, 2, 3, 7, 8, 9, and 10, 2022.

The following intake(s) were inspected:

- Intake: #00001125 – Complaint regarding nursing and personal support services;
- Intake: #00001987 – Fall of resident resulting in injury;

- Intake: #00004015 – Follow-up inspection to Compliance Order #002, O. Reg. 246/22 s. 34 (1) 3, General Requirements Falls Program. Compliance Due Date (CDD) August 23, 2022;
- Intake: #00004053 – Follow-up inspection to Compliance Order #001, O. Reg. 246/22 s. 53 (1) 1, Falls Prevention and Management. CDD July 26, 2022;
- Intake: #00004066 – Improper/Incompetent treatment of resident related to transferring and positioning;
- Intake: #00007084 – Improper/Incompetent treatment of resident by staff related to transferring and positioning resulting in fall and hospital transfer;
- Intake: #00007407 – Medication incident; and
- Intake: #00007922 – Unexpected death of a resident.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022-1473-0001 related to O.Reg. 246/22, s. 53 (1) 1. inspected by Debbie Warpula (577).

Order #002 from Inspection #2022-1473-0001 related to O.Reg. 246/22, s. 34 (1) 3. inspected by Debbie Warpula (577).

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

Falls Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Medication Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 123 (3) (a)

The licensee has failed to comply with Primacare's medication policies related to narcotic counting, documentation of medication incidents and narcotics, medication administration, and notification of medication incidents included in the required Medication Management Program for multiple residents.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, staff did not comply with Primacare's policies "Medication Incidents/Adverse Drug Reactions" revised October 2015, and "Narcotics and Controlled Drugs" revised November 2013.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director in September 2022, concerning a missing medication. The report which was further confirmed by interview with a Registered Practical Nurse (RPN) indicated that resident #009 had not received their medication and resident #012 had not received their scheduled medication but received a different medication in error. Resident #011's medication bubble pack had been tampered with, where a bubble was opened and re-taped with a medication inside which was not part of their scheduled medications. Additionally, all narcotic medications for that day were not signed for.

A review of Primacare's policy "Narcotics and Controlled Drugs 6-2-1" revised November 2013, indicated the following:

- two staff (one leaving and one coming on duty) must complete a narcotic count at the end/beginning of each shift;

- at the time of administration of a narcotic the registered staff would double check that the correct drug was being given to the correct resident;
- following the administration of the narcotic, the registered staff would record the administration of the medication on the Medication Administration Record (MAR) and on the narcotic counting form; and
- the Director of Care (DOC) would initiate an investigation into any missing narcotics or controlled drugs, or any packages that appeared to be tampered with using the home's investigation template.

A review of the home's investigation revealed that a Registered Practical Nurse (RPN) did not perform a narcotic count prior to leaving work; had not signed all the narcotics administered for five residents; and an investigative template was not utilized as part of the investigation.

The RPN reported that they should have discarded the narcotic with a second registered staff. They acknowledged that the medication rights of medication administration was not followed. They also advised that staff were required to document the administration of a narcotic as soon as it was given.

During an interview with the DOC, they said that they had not used the investigative template as part of the investigation of the medication incidents. The DOC stated that the RPN had not recorded the administration of narcotics for multiple residents and that the RPN had not followed the rights of medication administration by double checking that the correct drug was being given to the correct resident. The DOC confirmed that the medication policies related to narcotics and controlled drugs were not followed and resulted in medication incidents.

Sources: A Critical Incident (CIS) System report, medication incident reports, the home's policy "Medication Pass" (4.07-1 revised October 2015), "Medication Incidents/Adverse Drug Reactions" (6.04-1 revised October 2015), "Narcotics and Controlled Drugs" (6-2-1 revised November 2013), health records for multiple residents; and interviews with an RPN, two Assistant Directors of Care (ADOCs), and the DOC.
[577]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 124 (2)

The licensee has failed to ensure that as part of the interdisciplinary team, a pharmacist participated in a quarterly evaluation to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
During a record review of the home's Professional Advisory Committee (PAC) meeting notes dated October 18, 2022, Inspector #577 noted that a pharmacist was not listed in attendance.

During an interview with the DOC, they advised that the last meeting with a pharmacist occurred on July 5, 2022, for the period March – June 2022. They stated the home had a new pharmacy provider since October 6, 2022, and at the time of inspection they were recruiting for a pharmacist to participate in the evaluations.

Sources: A CIS System report, medication incident reports, PAC meeting notes; interviews with the DOC.
[577]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 124 (3) (c)

The licensee has failed to ensure that the quarterly evaluation of the medication management system included identified changes to improve the system.

Rationale and Summary
During a record review of the home's Professional Advisory Committee (PAC) meeting notes dated October 18, 2022, Inspector #577 noted that as part of their medication review, there were not any identified changes documented.

During an interview with the DOC, they confirmed that they reviewed previous PAC meeting

minutes and there were no identified changes documented to improve the medication management system.

Sources: A CIS report, medication incident reports, PAC meeting notes; interviews with the DOC.
[577]

WRITTEN NOTIFICATION: Annual evaluation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 125 (1)

The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider, and a registered dietitian, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
During an interview with the DOC, they stated that the home had not conducted an annual evaluation of the Medication Management System. They were also unable to provide any information which would indicate that the home had conducted an annual evaluation of the medication management system.

Sources: A CIS report, PAC meeting notes; interview with the DOC.
[577]

WRITTEN NOTIFICATION: Packaging of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 135

The licensee has failed to ensure that a medication had remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario

until administered to a resident or destroyed.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director in September 2022, concerning a missing medication and a tampered medication bubble pack for a resident's medication, where a bubble was opened and re-taped with a medication inside.

A review of the home's policy "Narcotics and Controlled Drugs – 6-2-1" revised November 2013, indicated that any blister type packages would be inspected for tampering and any package that appeared to be tampered with would not be used for resident care.

During an interview with an RPN, they advised that they had removed the medication from resident #009's medication bubble pack, thinking it was a different medication and put the tablet into resident #011's medication bubble pack with tape. They reported that they should have discarded the medication with a second registered staff.

Resident #011 was at risk when a medication was taped into their medication bubble pack.

Sources: A CIS report, medication incident reports, the home's policy "Narcotics and Controlled Drugs" (6-2-1 revised November 2013), health records for residents #009, and #011; interviews with an RPN, ADOC, and the DOC.
[577]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 79/10, s. 31 (3) (e)

The licensee has failed to ensure that the home's written staffing plan for the organized program of nursing services and the organized program of personal support services had been evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home's written staffing plan evaluation was requested by Inspector 721821 during the inspection. The home's Executive Director (ED) provided a copy of the home's most recent evaluation titled: "Nursing Staffing Plan Annual Evaluation (LTCHA Reg 31)". The review date of the evaluation was December 1, 2020.

The ED stated during an interview that the evaluation provided was the most recent evaluation of the program of nursing services they could find.

Sources: Nursing Staffing Plan Annual Evaluation, reviewed December 1, 2020; and interview with the ED.
[721821]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 140 (2)

The licensee shall:

A) ensure that drugs are administered to residents #009 and #012 in accordance with the directions for use specified by the prescriber;
B) provide training to the Registered Practical Nurse (RPN) on the home's policies for medication administration; specifically related to medication rights, narcotic counting, signage and wastage, according to Best Medication Practices to ensure residents are administered medications as prescribed; and
C) maintain a record of the training provided to the RPN, what the training entailed, and when the training was completed.

Grounds
Non-compliance with: O. Reg. 246/22 s. 140 (2)

The licensee has failed to ensure that drugs were administered to residents #009 and #012, in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director in September 2022, concerning a missing medication. The report indicated that resident #012 had not received their scheduled medication and resident #009 received resident #012's medication in error. Additionally, resident #011's medication bubble pack was tampered with, where a bubble was opened and re-taped with the wrong medication inside.

During an interview with the RPN, they advised that they had not followed the medication rights, specifically the right resident and the right medication, when they administered the wrong medication to resident #009, which had been taken from resident #011's medication bubble pack; and failed to administer scheduled medications to resident #009 and #012. They confirmed that they had inadvertently removed a medication from resident #009's medication bubble pack and re-taped it into resident #011's medication bubble pack which originally contained a different medication.

In an interview with the DOC, they confirmed that the RPN had not followed the medication rights when they administered medications on the date in question, resulting in medication errors involving residents #009 and #012. They also stated that the RPN should not have tampered with a bubble pack and should have wasted the medication instead.

Sources: A CIS report, medication incident reports, the home's policy "Medication Pass" (4.07-1 revised October 2015), "Medication Incidents/Adverse Drug Reactions" (6.04-1 revised October 2015), "Narcotics and Controlled Drugs" (6-2-1 revised November 2013), health records for residents #009, #011, and #012; interviews with the RPN, two ADOCs, and the DOC.
[577]

This order must be complied with by December 15, 2022

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:

A Compliance Order (CO) was issued December 1, 2021 during inspection #2021_928577_0003 under O. Reg. 79/10 s. 131 (2); and

Another CO was issued March 28, 2022 during inspection #2022_917213_0005 under O. Reg 79/10 s. 131 (2).

This is the first time the licensee has failed 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 Medication incidents

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 147 (1) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 147 (1) (a)

The licensee shall:

A) ensure that every medication incident(s) involving the RPN is/are documented using a medication incident form;
B) ensure every medication incident(s) involving the RPN is/are documented in the resident's progress notes, including what was given or not given and a factual account of what was done;
C) provide training to the RPN on the home's policy for medication administration, specifically related to Medication Incidents;
D) ensure the DOC reviews the home's medication policy, specifically related to medication incidents;
E) maintain a record of the training/policy review for the RPN and the DOC, what the training entailed, and when the training was completed; and
F) the DOC or their designate will audit any/all medication incident(s) involving the RPN to ensure they are documented as required until this Compliance Order is complied by an inspector.

Grounds
Non-compliance with: O. Reg. 246/22 s. 147 (1) (a)

The licensee has failed to ensure a medication incident involving resident #009 was documented and a written record was kept.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director in September 2022,

concerning a missing medication. The report indicated that a resident had not received their scheduled medication, and received a different medication in error.

A review of Primacare's policy "Medication Incidents/Adverse Drug Reactions - 6.04-1" revised October 2015, indicated that registered staff were to document using the Medication Incident Report for medication incidents. If the resident was involved with the medication incident, the resident was to be assessed with vital signs and the physician informed; a factual account of the medication incident was to be documented in the resident's progress notes to include what was given or not given and a factual account of what was done.

During a review of the home's investigation, Inspector #577 noted a missing medication incident report and no documentation in the resident's progress notes concerning the medication errors or physician notification.

During an interview with the RPN, they advised that they had administered an incorrect medication to resident #009, taken from resident #011's medication bubble pack; and failed to administer the correct medication to resident #009.

During an interview with the DOC, they confirmed that the RPN had made the medication errors and the DOC had not documented a Medication Incident Report for one of the residents and that registered staff did not document the details of the medication incident in the resident's progress notes.

The Licensee failed to document and keep a written record of the medication incident involving a resident not receiving their prescribed medication and instead, receiving a medication that was not prescribed for them.

Sources: A CIS report, medication incident reports, the home's policy "Medication Pass" (4.07-1 revised October 2015), "Medication Incidents/Adverse Drug Reactions" (6.04-1 revised October 2015), health records for multiple residents; interviews with the RPN, ADOCs, and the DOC. [577]

This order must be complied with by December 15, 2022

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 #002

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:

A CO was issued December 1, 2021 during inspection #2021_928577_0003 under O. Reg. 79/10 s. 135.

This is the first time the licensee has failed 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 Medication incidents

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 147 (1) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 147 (1) (b)

The licensee shall:

A) provide training to all registered staff on the home's policy for medication administration, specifically related to reporting Medication Incidents;

B) maintain a record of the training for all registered staff, what the training entailed, and when the training was completed; and
C) the DOC or designate will audit all medication incidents to ensure they have been reported as required until 30 consecutive days of adherence is achieved.

Grounds
Non-compliance with: O. Reg. 246/22 s. 147 (1) (b)

The Licensee has failed to ensure that the Medical Director of the Home was notified of the medication incident involving resident #009.

The Licensee has failed to ensure that the SDM and Medical Director of the Home were notified of the medication incident involving resident #012.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director in September 2022, concerning a missing medication. The report indicated that resident #012 had not received their scheduled medication and resident #009 had not received their scheduled medication and received a different medication in error.

A review of Primacare's policy "Medication Incidents/Adverse Drug Reactions - 6.04-1" revised October 2015, indicated that in the event of a medication incident involving a resident, staff were to ensure notification of family or the SDM, the Medical Director, the prescriber of the drug, the attending physician, and pharmacy provider. The policy further indicated that all documentation for the Medication Incident Report was to be forwarded to the DOC or designate, and they were to review all information received.

During an interview with the RPN, they advised that they had administered an incorrect medication to resident #009, taken from resident #011's medication bubble pack; and failed to administer the scheduled medication to resident #009.

During a record review, Inspector #577 found that the Medical Director was not notified of the medication incident involving resident #009.

During a review of resident #012's record and medication incident report, the inspector found that the SDM and Medical Director were not notified of the medication incident involving this resident.

The Licensee failed to notify the Medical Director of medication incidents involving residents #009 and #012. The Licensee also failed to notify resident #012's SDM of the medication incident.

Sources: A CIS report, medication incident reports, the home's policy "Medication Pass" (4.07-1 revised October 2015), "Medication Incidents/Adverse Drug Reactions" (6.04-1 revised October 2015), "Narcotics and Controlled Drugs" (6-2-1 revised November 2013), health records for multiple residents; and interviews with the RPN, ADOC, and the DOC.
[577]

This order must be complied with by January 18, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 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 $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:

A CO was issued December 1, 2021 during inspection #2021_928577_0003 under O. Reg. 79/10 s. 135.

This is the first time the licensee has failed 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 Transferring and positioning techniques

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22, s. 40

The licensee shall:

A) ensure that the Daily Portable Floor Lift Inspection Checklist is completed once per shift on each mechanical lift on a specific home area where a lift may be housed and used;
B) complete an audit to ensure that the Daily Portable Floor Lift Inspection Checklist on the specified home area is being completed in accordance with the home's policy;
C) maintain records of the Daily Portable Floor Lift Inspection Checklist and the audits until this Compliance Order has been complied by an inspector; and

D) ensure that a resident is transferred with their assessed sling size per their plan of care and in accordance with the home's lift and transfers policy.

Grounds
Non-compliance with O. Reg 246/22 s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted two different residents with transfers.

Rationale and Summary
In August 2022 a resident was being transferred with a mechanical lift. During the transfer the resident fell which caused an injury. One of the PSWs who was assisting with the transfer at the time stated that they did not know which size sling the resident should have been using at the time of the incident. The Assistant Director of Care (ADOC) at the time of the incident, stated that the resident's sling size was not noted in their plan of care at that time. A review of the care plan and Kardex for the resident showed that their sling size was not documented until after the incident.

A review of the home's investigation of the incident showed that the staff did not comply with the home's safe lifts and transfers policy. During an interview with ADOC at the time of the incident, they stated that the PSWs should not have performed the transfer as it was unsafe for the resident.

During the inspection, Inspector #721821 observed that the incorrect sling had been placed on a chair in the resident's room near their bed. When interviewed, a PSW stated that there were not any residents on the resident's home area who required the size of the sling observed by the inspector. When questioned, a PSW who performed morning care for the resident that day, stated they had used the sling that had been placed on the chair in the resident's room which was the wrong size based on their plan of care.

[721821]

In September 2022 another resident was being transferred to bed by two PSWs with the aid of a mechanical lift. The resident fell from the lift which caused an injury.

Review of the policies, Lifts and Transfer (05-42, Current Version December 2017) and Pre-Start Safety Check for Mechanical Lifts (05-44, Current Version October 2017) indicated that any

mechanical lift must have been checked prior to use which followed the tasks in the Pre-Start Safety Check list.

Interviews with staff indicated that they were unaware that a pre-start safety checklist for each mechanical lift was required to be filled out at each shift. No check list was completed on the date of the incident for the Hoyer lift used to transfer the resident, as indicated by the blank spaces for that date on the checklist itself.

[740899]

Sources: Review of residents' care plans, and Kardex files, Point Click Care record review for residents including fall assessments, head injury routine, the pre-start safety check list for September 2022, the home's lift and transfers policies, the home's Critical Incident investigation notes, review of a CIS report; interviews with multiple PSWs and the ADOC at the time of the incident; and observations during the inspection.
[721821 and 740899]

This order must be complied with by December 22, 2022

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londondistrict.mltc@ontario.ca

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.