Ontario

Inspection Report Under the
**Fixing Long-Term Care Act, 2021**

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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

# Amended Public Report Cover Sheet (A1)

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| **Amended Report Issue Date:** December 4, 2024 |
| **Original Report Issue Date:** November 22, 2024 |
| **Inspection Number:** 2024-1544-0003 (A1) |
| **Inspection Type:**<br>Complaint<br>Critical Incident<br>Follow up |
| **Licensee:** The Corporation of the City of Peterborough and The Corporation of the County of Peterborough |
| **Long Term Care Home and City:** Fairhaven, Peterborough |

## AMENDED INSPECTION SUMMARY

This report has been amended to:

Compliance Order (CO) #002- Condition #4 changed to include supervisors may complete audits.

Compliance Order #004- Condition 4- -changes to include the managers and/or supervisors may complete daily audits during an outbreak. The ESS and ESM will continue to oversee the daily completed audits so that if concerns were identified by the manager and supervisors completing the audits they can take or provide guidance, so that relevant corrective action can be taken to prevent reoccurrence.

Compliance Order #004-Amendment to the Infection Prevention and Control Program, to include the Legislative Reference to the order. FLTCA, 2021, s. 155 (1) (a).

Compliance Order #005- changes to include the managers and/or supervisors may complete daily audits during an outbreak. The ESS and ESM will continue to oversee the daily completed audits so that if concerns were identified by the manager and supervisors completing the audits they can take or provide guidance, so that relevant corrective action can be taken to prevent reoccurrence.

Compliance Order #005-Amendment to CMOH and MOH, to include the Legislative Reference to the order. FLTCA, 2021, s. 155 (1) (a).

Amended Inspection Report, for CO #002, #004, #005 with a served date of December 4, 2024.
Compliance Order #001 and #003 are included in this report for reference; however, were not amended; therefore, the served date remains November 22, 2024.

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## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9-11, 15-18, 21-24, 2024.

The following intake(s) were inspected:

Two intakes related to an allegation of financial abuse.

Follow-up #1 -regarding Compliance Order (CO) #005 Emergency plans, specific O. Reg. 246/22 - s. 268 (1), with a CDD July 5, 2024.

Follow-up #1 -regarding CO #008 from inspection #2024-1544-0001, Doors in a home, specific to O. Reg. 246/22 - s. 12 (1) 3, with a CDD July 5, 2024.

Follow-up-regarding CO #001 from inspection #2024-1544-0001, Communication and response system, specific to O. Reg. 246/22 - s. 20 (e), with a CDD July 5, 2024.

Follow-up #1 on CO #004, from inspection #2024-1544-0001, Hazardous substance, specific to O. Reg. 246/22 - s. 97, with a CDD July 5, 2024.

Follow-up #1 on CO #003, from inspection #2024-1544-0001, 24-hour admission care plan, specific to O. Reg. 246/22 - s. 27 (2) 1, with a CDD July 5, 2024.

Follow-up #1 on CO #002, from inspection #2024-1544-0001, Compliance with manufactures' instructions, specific to O. Reg. 246/22 - s. 26, with a CDD July 5, 2024.

Follow-up #1 on CO #006, from inspection #2024-1544-0001, Emergency plans, specific to O. Reg. 246/22, s. 268 (14), with a CDD July 5, 2024.

Follow-up #2, on CO #001, from inspection #2023-1544-0002, Infection prevention and control program, specific to O. Reg. 246/22, s. 102 (2) (b), with a CDD of February 9, 2024.

Follow-up #3, on CO #001 from inspection #2023-1544-0001, Transferring and positioning techniques, specific to O. Reg 79/10, s. 36, with a CDD August 25, 2023.

Follow-up # 1 on CO #010, from inspection #2024-1544-0001, Housekeeping, specific to O. Reg. 246/22 - s. 93 (2) (b) (iii) with a CDD July 5, 2024.

Follow up #1 on CO #007, from inspection #2024-1544-0001, Reporting certain matters to Director, specific to FLTCA, s. 28 (1)2, with a CDD July 5, 2024.

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Follow up 1 on CO #009, from inspection #2024-1544-0001, Food production, specific to O. Reg. 246/22, s. 78 (6) (b) with a CDD July 5, 2024.

A Intake related to a complaint related to concerns with personal care of a resident.

A Intake related to a complaint related to concerns with a medication administration error.

A Intake a complaint related to concerns with continence care and concerns related to neglect.

## Previously Issued Compliance Order(s)

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

Order #005 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 268 (1) .

Order #008 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 12 (1) 3.

Order #001 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 20 (e).

Order #004 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 97.

Order #003 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 27 (2) 1.

Order #002 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 26.

Order #006 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 268 (14).

Order #001 from Inspection #2023-1544-0002 related to O. Reg. 246/22, s. 102 (2) (b).

Order #001 from Inspection #2023-1544-0001 related to O. Reg. 79/10, s. 36.

Order #010 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 93 (2) (b) (iii).

Order #007 from Inspection #2024-1544-0001 related to FLTCA, 2021, s. 28 (1) 2.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #009 from Inspection #2024-1544-0001 related to O. Reg. 246/22, s. 78 (6) (b).

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints

# AMENDED INSPECTION RESULTS

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

**Rationale and Summary:**

A Critical Incident Report (CIR) and a complaint was submitted to the Director regarding an allegation of financial abuse toward a resident. The Registered Nurse (RN) started an investigation regarding the allegation.

The home's policy indicated the Registered Staff/management team will begin an investigation by having the persons involved complete in detail the incident investigation form. The incident investigation form also indicated that the registered staff were to complete a Risk Management note.

The Director of Care (DOC) provided a red folder which contained the investigation completed regarding the alleged financial abuse of a resident. The red folder did not contain the incident investigation form.

The DOC acknowledged there was no incident investigation form completed as per the home's Zero Tolerance of Abuse and Neglect policy and confirmed there was no Risk Management note.

When the Incident Investigation form and Risk Management note were not completed by staff the investigation for the allegation of financial abuse by a resident was incomplete.

**Sources:** The home's policy, a resident 's clinical records, interview with the DOC.

## WRITTEN NOTIFICATION: Conditions of Licence

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with CO #009 from inspection #2024-1544-0003 served on May 2, 2024, with a compliance due date of July 5, 2024, all aspects of CO #009 was not complied.

Specifically, the licensee failed to ensure The Nutritional Services Manager, in collaboration with the Registered Dietitian and the Executive Director had institutional food service equipment to keep cold foods at a safe temperature during dining services. The Audits conducted during dining service to ensure cold foods were being prepared, transported and held at safe temperature during a four week auditing period indicated no corrective action was taken when a deficiency was identified.

**Rationale and Summary:**

The audits for the main kitchen indicated that when cold food was prepared and the temperature was recorded above 40 degrees Fahrenheit, corrective action occurred, however a second temperature was not recorded to ensure the temperature of the cold food had decreased to 40 degrees Fahrenheit or below. The NSM agreed there was no second temperature recorded on the audit or recorded in the kitchen indicating the cold food was below 40 degrees Fahrenheit

prior to transporting the food to the food cart and to the resident home areas.

The audits indicated that cold food and beverages were removed from the food cart upon arrival to the Resident Home Area and they were placed in either the fridge or on ice. The audit indicated that the cold food (proteins) temperatures were to be taken and recorded before meals were served and cold food temperatures must be below 40 degrees Fahrenheit/ 4 degrees Celsius. Review of the daily cold food audits for four weeks indicated the cold food holding temperatures were recorded above 40 degrees Fahrenheit on all audit days but one. The Food Service Manager (FSM) agreed corrective action to keep cold food below 40 degrees Fahrenheit had not occurred when a deficiency was identified during the auditing period.

The home had purchased institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold foods and beverages at a safe temperature. The NSM acknowledged that despite purchasing the equipment the cold food often remained above 40 degrees Fahrenheit and that they would be looking at other interventions to keep cold foods at or below 40 degrees Fahrenheit.

**Sources:** Review of audits, interview with the NSM.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Written Notification NC #002**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
There was no history of non-compliance (NC) with FLTCA, 2021, s.104(4) issued for the Compliance Order #009 from Inspection Report #2024-1544-0003.

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

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

## WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.**
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept

closed and locked when they are not being supervised by staff.

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

**Rationale and Summary:**

The Inspector observed that the equipment room door in an RHA was closed, unlocked, and unsupervised, which provided residents with easy access to the room.

A Registered Practical Nurse (RPN) confirmed that all equipment room doors in the home were to be closed and locked at all times for resident safety. The RPN immediately proceeded to lock the equipment room door.

Failure to ensure that all doors leading to non-residential areas were closed and locked, when not being supervised by staff, has placed residents' safety at risk.

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

2. The licensee failed to ensure doors leading to non-residential area are kept closed and locked when they are not being supervised by staff

**Rationale and Summary:**

It was observed the equipment storage door on the RHA was open and unlocked, inside the equipment storage room was a lift and slings. A Personal Support Worker (PSW) confirmed the door to the equipment room is a self-closing door and reported it was not locking when the door closed. The PSW reported they would

put in a maintenance request to have the door fixed. That same day Inspector reported the observation to the DOC, and they indicated they would let the Environmental Service department know the door needed to be fixed.

The next day an observation was made with the Resident Care Manager (RCM) to test if the door was fixed, the door was opened and when the door was released the door closed and locked. The RCM agreed the door to the storage equipment room was to be kept locked.

There was low risk to resident safety when the door did not latch, there was no risk to the residents' health.

**Sources:** Observations, interviews with staff and the DOC.

## WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.**
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee has failed to ensure that an interdisciplinary assessment related to a resident's safety risks for smoking outside and elopement risk off the property was completed.

**Rationale and Summary:**

A complaint was received from a resident’s Substitute Decision Maker (SDM) regarding the concerns of the resident’s personal care and leaving the home’s

property.

The resident went off the property with a co-resident. The RN documented, the resident's SDM informed them that the resident was off the property with a co-resident. Later that day the resident and co-resident returned to the home together and the RN instructed the co-resident not to take the resident off the property.

Upon the resident's return to the home that day, there was no indication that any assessment had been completed pertaining to the resident's safety risk, including how long the resident was outside, or whether the resident sustained any injuries. The resident's clinical records did not specify how to monitor the resident when they go outside. There was no process nor interventions in place for resident safety related to the resident going outside the home.

The RN indicated the resident goes outside multiple times a day. The RN agreed that although the resident was a low elopement risk, the resident was not safe to leave the property on their own.

Failure to ensure the resident's plan of care was based on an assessment of their safety risk related to going outside placed the residents at risk of elopement.

**Sources:** Clinical records, and, interviews with staff.

## WRITTEN NOTIFICATION: Personal care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 36**
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

The licensee failed to ensure that a resident received individualized personal care, including hygiene care and grooming, daily.

**Rationale and Summary:**

A complaint was submitted to the Director from the resident's SDM regarding concerns about personal care, including daily grooming.

The resident's clinical records did not indicate how often the resident was to be offered grooming. The clinical records indicated the resident required minimal assistance/supervision with grooming.

The resident's clinical records indicated that no shaving was completed for 16 days for one month, and four consecutive days for another month. The documentation further indicated that the resident was not groomed for seven days in a row. There was no documentation mentioning why grooming was not provided to the resident.

The Personal Support Worker (PSW) confirmed that the resident did not receive grooming on those specified dates. The DOC confirmed that the resident should have received grooming daily and this information will be updated.

Failing to provide proper personal hygiene and grooming may affect resident's comfort and dignity.

**Sources:** A photo of a resident, the resident's clinical records, and interview staff.

## COMPLIANCE ORDER CO #001 Maintenance services

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)**

Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

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

1. The Director of Care (DOC) and Environmental Service Manager (ESM) or their designates will make a list of all the different types of mechanical lifts currently being used in the home by staff to lift and transfer residents. Keep a documented record of the different mechanical lifts in the home and provide the list upon request of the Inspector.

2. The DOC or/designate, and ESM or /designate will review each manufacturer's instructions for the different mechanical lifts being used in the home. The DOC or designate will review the type of sling the manufacturer recommends for each type of mechanical lift and will develop and implement what safety checks are needed to be completed by staff prior to each mechanical lift use. The DOC or designate will develop and implement on how the safety checks will be documented by staff. Keep a documented record of the documentation implemented to ensure staff check the mechanical lifts and slings as per the manufacturer's instructions. Provide the documentation upon request of the Inspector.

3. The DOC or /designate, and ESM or/designate will develop and implement for each mechanical lift being used in the home an individualized checklist as outlined in the manufacturer instructions. The checklist will include instructions on the frequency of these checks, what department and individual will be responsible for

the safety checks and how staff are to document the mechanical lift checks. Keep a documented record of the checklist developed and implemented and provide the documentation upon request of the Inspector.

4. The DOC or designate will keep a current list of all employed registered staff and PSW staff including agency staff employed at the home. The DOC or designate will provide in-person education to all the Nurse Management staff regarding the checklist for slings, mechanical lifts, and the required documentation. The Nurse Management staff or designate will provide in person training to the registered staff, PSW, and agency staff on the different sling and mechanical lift safety checks to ensure the appropriate sling is used with the appropriate mechanical lift and where to document these checks. Once the staff have received the in-person education, the DOC or designate will have each PSW and registered staff do a return demonstration on how to check each different mechanical lift and sling and the staff will verbally acknowledge to the educator where to document these checks and confirm their knowledge regarding certain sling use with the appropriate mechanical lift. Keep a documented record of the content of the education, the staff's name, position, the date of the training, and the staff signature indicating they have been educated on this process. Provide upon request of the Inspector.

5. The ESM or /designate will educate the environmental service team on the developed individualized mechanical lift checklist and the frequency of these checks. The ESM will have each member of the environmental service team that will be checking the mechanical lifts do a return demonstration on how the lifts will be checked and will verbally acknowledge to the educator the process to ensure the mechanical lifts are checked at the required frequency and how the mechanical lift checks are documented. Keep a documented record of the content of the education provided, the staff's name and date the staff was educated and their signature indicating the education was provided. Provide upon request of the Inspector.

6. Once all staff have been educated the DOC or designate will audit twice a week for four weeks each home area to ensure staff are documenting they have checked all slings and mechanical lifts as per the manufacturer's instructions. Keep a documented record of the audits indicating the mechanical lifts and slings have been checked and staff have documented the checks as per the manufacturer's instructions. If a staff has not documented the mechanical lift/sling checks keep a documented record of the date, the name of the staff, and the corrective action taken. Provide the documented audits upon request of the inspector.

7. Once all the environmental service staff have received their in-person education the ESM will audit once a week for four weeks to ensure that the environmental service staff have checked all mechanical lifts as per the required frequency and that the documentation is complete as per the checklist for each individualized mechanical lift. Keep a documented record of the audits for the mechanical lift checks. If an audit was incomplete or not completed at the required frequency document the date, the name of the staff, and the corrective action taken with the staff. Provide the documented audits upon request of the inspector.

**Grounds**
The licensee has failed to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained at a level that meets manufacturer specifications, at a minimum.

**Rationale and Summary:**

A follow up inspection was conducted regarding two compliance orders that included staff following the manufacturer's safety instructions when using the mechanical lifts and slings when transferring a resident.

There were several different types of floor mechanical lifts in use and the slings provided for transferring residents were not manufactured for the mechanical lifts.

The manufacturer instructions for each floor mechanical lift and sling provided direction on when and how to complete the preventative maintenance. The safety checks for the floor mechanical lifts were not individualized to meet the different manufacturer instructions for inspecting the lifts. The slings in use were not manufactured for the floor mechanical lifts in use to transfer residents. There was no documented record of the safety checks for each different type of floor lift and sling as per the manufacturer's instructions.

The DOC acknowledged there were different types of floor mechanical lifts and the slings were a different brand than the floor mechanical lifts that were being used. The DOC reported a representative had indicated that the slings were interchangeable with other manufacturer's mechanical lifts. The DOC acknowledged that the manufacturer's instructions for the different types of floor mechanical lifts in the home indicated that other slings were not interchangeable.

The home's policy indicated the DOC would review the sling and lift safety checklists, audits, and removal of slings from service. The nursing staff would participate in the preventative maintenance for the daily sling and lift safety check. The Environmental service staff would complete the preventative maintenance on all mechanical lift as per the manufacturer's instructions and maintain a clear record of inspections.

The ESM confirmed that the Environmental service staff were not checking the mechanical lifts as indicated in the manufacturer's instructions for preventative maintenance.

The resident's safety was at an increased risk when staff/management did not check the lifts and slings as per the manufacturer's instructions.

**Sources:** The home's policy, email correspondence from a mechanical lift manufacturer, review of the Mechanical Safety Check audits, mechanical lifts and

slings manufacturer's instructions, interview with the DOC and ESM.

**This order must be complied with by** February 7, 2025

## COMPLIANCE ORDER CO #002 Food production

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)**
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).
**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The Nutritional Service Manager (NSM) and the Registered Dietitian (RD) will collaborate and revise the food production policy to ensure food and fluids are prepared, stored and served using methods to prevent adulteration and food borne illness as per current evidence-based practice, and if there are none, best practice.

2. The NSM or management designate will provide in person education on the updated policy to all the dietary aids. Keep a documented record of the education provided, the names of the staff that attended, the date they attended, provide the documentation upon request of the Inspector.

3. Post training the NSM or designate, who must be a manager will administer a supervised test to all the dietary staff. Ensure all staff complete the testing independently and without aid. Ensure that any staff receiving a final grade of less than 85% on the test is provided retraining and is retested on the materials. Maintain

a documented record of the test materials, the administration record, and the finals grades for each participant as well as the date the test was administered. Provide the documentation upon request of the Inspector.

4. The NSM, management designate and/or supervisors will conduct audits of the food temperatures prior to the point of service for all meals in the dining room for four weeks to ensure that food and fluid temperatures are outside of the danger zone. Provide on the spot corrective actions if deviations are noted. Keep documented records of the audit, the date of the audit, meal type, dining room locate and corrective action. Weekly the NSM will analyze the audits and provide further corrective action to staff based on trends observed. Keep a documented record of the weekly analysis completed, any trends identified and what corrective action occurred. Provide the audits upon request of the inspector.

**Grounds**
The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored and served using methods to prevent adulteration and food borne illness.

**Rationale and Summary:**

Upon inspecting Compliance Order #009 Inspector noted the cold food was consistently above 4 degrees Celsius over the four-week auditing period.

The Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes a Working Paper of the Ontario LTC Action Group 2019, indicates hot foods was to be maintained at a minimum temperature of 60 degrees Celsius throughout meal service, and cold foods at a maximum of 4 degrees Celsius throughout meal service. This document also indicated that policies and procedures for food production include as a minimum: Hazard Analysis and Critical Control Points (HACCP) principles, including time and temperature guidelines for food purchasing,

preparation, holding, service, and storage. The Government of Canada Safety Tips reports that everyone should practice general food safety precautions at all times: Bacteria can grow in the zone between 4 degrees Celsius and 60 degrees Celsius. Keep cold foods cold at or below four degrees Celsius and keep hot foods hot at or above 60 degrees Celsius.

The NSM indicated they had spoken to the RD and acknowledged that cold food should be held below 4 degrees Celsius until serving. The NSM acknowledged that cold food temperatures being recorded above 4 degrees Celsius was ongoing and they were currently working on implementing new interventions to keep the cold food below 4 degrees Celsius.

The home's policy did not specify the temperatures that hot and cold food should be maintained at during food production, holding and meal service. The policy did not indicate the corrective action when cold food was above 4 degrees Celsius to prevent food borne illnesses. The policy had no direction on how cold and hot beverages in the production system are prepared, stored and served. The NSM agreed there are currently no guidance documents the dietary staff are following for food safety.

The residents' health may have been at an increased risk when the cold food in the food production system was not prepared, stored, and served at the required temperatures and the home's policy was not updated for staff to reference food safety.

**Sources:** The home's policy titled, best practice guidance documents, Government of Canada, General Food Safety Tips, Food Handlers, Ministry of Health and Long Term Care, interview with NSM.

**This order must be complied with by** February 7, 2025

## COMPLIANCE ORDER CO #003 Housekeeping

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)**
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

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

1. The ESS or ESM or Executive Director is to Update the home's policies and procedures for housekeeping shortages, including during a confirmed disease outbreak, to indicate which role(s) is responsible for the redeployment of housekeeping staff on shift, and indicate, the priority of each housekeeping role on shift in the redeployment process.

2. Train the home's housekeeping staff (including any staff cross-trained for housekeeping), Registered Nurse's (RN)'s, Schedulers, and Management on the home's updated policies and procedures.

3. Keep a documented record of the training, including the date, training content details, and the names and roles of staff trained. Provide the record to the inspector immediately upon request.

4. Develop and implement a process to document and keep a record, of when and

why housekeeping staff were or were not redeployed, during a housekeeping staffing shortage, any findings and/or corrective action taken as to prevent re-occurrence of not redeploying housekeeping staff when required. Provide the records to inspector immediately upon request.

**Grounds**
The licensee has failed to ensure an organized program of housekeeping under clause 19 (1) (a) of the Act, that procedures implemented for cleaning of the home, including resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

**Rationale and Summary:**

The Inspector conducted a mandatory Infection Prevention and Control (IPAC) inspection, in accordance with IPAC checklist.
Review of the home's Housekeeping Coverage policy indicated a procedure for Environmental Services Supervisor (ESS) and Scheduling Department to follow in the event of short staffing, to ensure that staff would be redeployed to cover the RHA.
Two Scheduler's and one RN confirmed that they were not aware of the home's Housekeeping Coverage policy or its direction. The home's Surge Learning, related to a previous compliance order and follow up inspection, did not include Staff training on the home's newly developed Housekeeping Coverage policy.

The home's Scheduling Department guidance document indicated that the Nurse in Charge and/or Manager were to redeploy housekeeping roles on duty, following a certain order.

The Schedulers confirmed that when the home was unable to fill an RHA housekeeping shortage, RN's and/or Managers were responsible to redeploy housekeeping staff on shift. Additionally, they confirmed that Schedulers were only

responsible to provide the housekeeping compliment for redeployment guidance.

A Housekeeper and the Scheduler's confirmed that for three consecutive days two RHA's were in a confirmed disease outbreak, and that these resident units had housekeeping shortages. The Schedulers, ESS, and Environmental Services Manager (ESM), all confirmed that there was other housekeeping staff working during these days in other roles. The Schedulers, ESS and ESM reported these housekeepers should have been redeployed during the housekeeping shortage and were not.

The ESS confirmed that on the Monday during the time of the outbreak they reviewed the weekend housekeeping schedule and noted staffing shortages on the weekend. Furthermore, they confirmed that they were aware that the home continued to have housekeeping shortages on Monday, and they did not redeploy housekeeping staff.

The Housekeeper confirmed that they were working day shift, for all three days, on one of the resident home areas. The Housekeeper reported that they were not co-horted to the outbreak area due to a housekeeping shortage. They confirmed that they did not complete the required twice daily cleaning and disinfecting of contact surfaces throughout the home area and/or within resident rooms during their shifts.

The ESM confirmed that during an outbreak and housekeeping shortage, it was unlikely that one housekeeper would be able to complete all required housekeeping tasks for two home areas, which included the cleaning/disinfecting of four pre-assigned resident rooms and to conduct touchpoint cleaning twice per day in numerous resident rooms.

Failure to ensure that procedures were implemented for cleaning of the home, specifically that during a staffing shortage that housekeeping staff were redeployed to ensure required cleaning in the home was completed, has placed residents'

health and well-being at risk.

**Sources:** The home's Housekeeping Coverage Policy, Staff Surge Learning Compliance Order Training, Scheduling Department Guidance Document, and Interviews with Staff, ESS, and ESM.

**This order must be complied with by** February 7, 2025

## COMPLIANCE ORDER CO #004 INFECTION PREVENTION AND CONTROL PROGRAM

NC #009 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)]:**
Inspector is ordering the licensee to:

1. Infection Prevention and control (IPAC) Lead will collaborate with Department Managers to review all job roles within the home, develop a list and keep a record of the IPAC skills that are required for each role. The records will be made available to inspector immediately upon request.

2. IPAC Lead will develop and implement a process to ensure the auditing of all job roles within the home are audited to ensure that all staff can perform the IPAC skills required of their role, at least quarterly. The process shall include a documented auditing schedule for IPAC Lead oversight, and a record of all quarterly audits

conducted, for each job role within the home, to ensure that all staff can perform the IPAC skills required of their role. The records will be made available to inspector immediately upon request.

3. Environmental Service Manager (ESM) or Environmental Service Superiors (ESS) will conduct weekly audits of all home areas to ensure housekeeping tasks were completed as required during non-outbreaks, for six weeks.

4. ESM, ESS, managers, and/or supervisors will conduct daily audits of all home areas to ensure housekeeping tasks were completed as required during a suspect/confirmed outbreak. The ESS and ESM will continue to oversee the daily completed audits so that if concerns were identified by the manager and supervisors completing the audits they can take or provide guidance, so that relevant corrective action can be taken to prevent reoccurrence. These audits are to be conducted immediately upon a suspect/confirmed outbreak, and daily until the outbreak is declared over.

5. Document and keep a record of all identified audits, as per conditions #4, and #5 and IPAC Standard 7.3, that includes the name and role of auditor, name and role of staff being audited, home area name/location, date and time of audit, any findings of audit and any corrective action taken if task was not completed and/or demonstrated as required. Provide the records immediately upon Inspector request.

6. Update the home’s housekeeping policies/procedures, including at a minimum, any housekeeping Task Records and housekeeping Job Routines, to indicate the required frequency of cleaning and disinfecting during non-outbreaks and suspect/confirmed outbreak, and ensure clear direction provided to housekeeping staff on what contact surfaces areas are to be cleaned and disinfected throughout the home area and/or within resident rooms, and which resident rooms are required to be cleaned and disinfected during a confirmed outbreak and the frequency.

**Grounds**
1. The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control was implemented. Specifically, the licensee failed, at least quarterly, 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.

**Rationale and Summary:**

The Inspector conducted a mandatory IPAC inspection, in accordance with IPAC Checklist. Review of IPAC Lead's quarterly audits confirmed that the audits were not conducted to ensure that all staff can perform the IPAC skills required of their role, specifically for Laundry Services and Recreational Program staff.

The IPAC Lead confirmed that they were not conducting quarterly audits to ensure that all staff can perform the IPAC Skills required of their role, in every department.

The IPAC Lead confirmed that they provided the home's management team with an IPAC audit template for all department managers to conduct quarterly audits of their staff as to ensure that all staff can perform the IPAC skills required of their role.

The IPAC Lead confirmed that they were uncertain if all department managers had implemented the IPAC auditing process of their staff. Subsequently, IPAC Lead confirmed that the Laundry Services and Recreational Program managers did not conduct any IPAC audits as to ensure that all Laundry Services and Recreational Program staff can perform the IPAC skills required of their role.

Failure to ensure that, at minimum, quarterly audits were conducted to ensure that

all staff can perform the IPAC skills required of their role has placed the residents and staff at increased risk for disease transmission.

**Sources:** The home's IPAC audits, and interviews with Staff and IPAC Lead.

2. The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control was implemented. Specifically, the licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that there were policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, that surfaces were cleaned at the required frequency, and that adequate personnel were available on each shift to complete required surface cleaning and disinfection, in accordance with IPAC Standard, Additional Requirement 5.6 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

**Rationale and Summary:**

The Inspector conducted a mandatory IPAC inspection, in accordance with IPAC Checklist. A Housekeeper confirmed that they were working for three consecutive days on a resident home area that was in a confirmed outbreak. The housekeeper confirmed that during this time they were not co-horted to the outbreak home area due to a staffing shortage. The Housekeeper confirmed that housekeepers were responsible for deep cleaning pre-assigned resident rooms daily during an outbreak. The housekeeper confirmed that they did not complete the required twice daily cleaning and disinfecting of contact surfaces throughout the home area and/or within resident rooms during their shift.

The ESS confirmed that during an outbreak, co-horted housekeepers were required to complete a deep clean daily on pre-assigned resident rooms, as indicated on the

Housekeeping Task Record, and then "police" the other resident rooms. The ESS also confirmed that, during a confirmed outbreak and staffing shortage, it was unlikely that one housekeeper would be able to complete the required twice daily cleaning and disinfecting of contact surfaces throughout the outbreak home area and/or within resident rooms when responsible for two home areas.

The home's Housekeeping Task Record, used during an outbreak for housekeeping staff to document housekeeping tasks, did not indicate a required cleaning and disinfecting frequency for contact surfaces and/or resident rooms. The record only indicated a required daily cleaning and disinfecting for the pre-assigned resident rooms. The record did not indicate what contact surfaces were to be cleaned throughout the home area and/or within resident rooms.

The IPAC Lead and ESM, confirmed that the home's housekeeping policies/procedures, housekeeping job routine and Housekeeping Task Record, did not indicate what contact surfaces were to be cleaned and disinfected during contact surface cleaning throughout the home area and/or within resident rooms when the home was in an outbreak. The ESM and IPAC Lead both confirmed that the home's housekeeping policies/procedures, housekeeping job routine and Housekeeping Task Record needed to be updated to reflect these requirements.

Review of the home's cleaning frequency policy did not indicate a required frequency for cleaning and disinfecting, during non-outbreaks and outbreaks, of contact surfaces throughout a home area and/or within resident rooms. The policy indicated a "Risk Stratification Matrix" and did not indicate a legend for the user to determine a required frequency based on scoring and a quantitative and qualitative analysis.

The Housekeeper confirmed that they were not aware of the home's policy for cleaning frequencies and its direction and/or how to use the indicated "Risk Stratification Matrix" to determine a cleaning and disinfecting frequency for contact

surfaces and/or resident rooms.

The ESM and IPAC Lead confirmed that the home's process for cleaning and disinfecting contact surfaces, during an outbreak, included resident light switches, room and washroom door handles and did not include the cleaning and disinfection of resident call bells, bed rails, washroom handrails, or any other surfaces within the resident's room.

The IPAC Lead and ESM, confirmed that the home's policies and procedures do not provide clear direction to staff on a required cleaning and disinfecting frequency for contact surfaces and/or resident rooms, during non-outbreaks and outbreaks.
The home's policy that reflected department specific outbreak responsibilities and housekeeping job routines, confirmed that a required cleaning and disinfecting frequency, during an outbreak, of contact surfaces and/or resident rooms was not indicated.

The ESM confirmed that the home's Housekeeping Task Record had been updated and resubmitted the updated record to Inspectors. Subsequent review of the home's updated Housekeeping Task Record, confirmed that the record indicated some examples of contact surfaces to be cleaned and disinfected, twice daily, but did not include the cleaning and disinfecting of resident calls bells, bed rails or inside a residents washroom.

Failure to ensure that policies and procedures were in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, that contact surfaces were cleaned at the required frequency and that adequate personnel were available on each shift to complete required surface cleaning and disinfection, has placed residents at increased risk for disease transmission and prolonged disease outbreak.

**Sources:** IPAC Checklist, the home's IPAC and housekeeping policies, Interviews

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

**Central East District**
33 King Street West, 4th Floor
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Telephone: (844) 231-5702

with Staff, ESS, ESM, and IPAC Lead.

**This order must be complied with by** February 7, 2025

**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 $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:**

O. Reg. 246/22, s. 102 (2)(b) included: CO issued on November 14, 2023, in inspection #2023-1544-0002.
O. Reg 246/66 s. 102 (2) (b) included: WN issued on July 26, 2023, in inspection # 2023-1544-0001

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

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

## COMPLIANCE ORDER CO #005 CMOH and MOH

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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

1. The ESM and IPAC Lead will collaborate, develop and provide in-person training to all housekeeping staff, including staff cross-trained for housekeeping duties, that includes, at a minimum: the requirement of twice daily cleaning of all high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas during outbreaks and the procedures related to that requirement such as: cleaning times, surfaces and which resident rooms are to be cleaned, documentation of cleaning, disinfectant product name and contact time, breaking the chain of transmission at resident doorways,

etc.

2. Keep a documented record of the training in condition #1, including: date, content, trainer name (ESM or IPAC Lead) and signature, list of all housekeeping staff and staff cross-trained for housekeeping duties, that require the training, and staff signatures attesting that they have received and understand the training. Provide the records immediately upon Inspector request.

3. ESM or ESS will conduct weekly audits, for six weeks, of all home areas to ensure that housekeeping tasks were completed as required during non-outbreaks.

4. ESM, ESS, managers, and/or supervisors will conduct daily audits of all home areas to ensure housekeeping tasks were completed as required during a suspect/confirmed outbreak. The ESS and ESM will continue to oversee the daily completed audits so that if concerns were identified by the manager and supervisors completing the audits they can take or provide guidance, so that relevant corrective action can be taken to prevent reoccurrence. These audits are to be conducted immediately upon a suspect/confirmed outbreak, and daily until the outbreak is declared over.

5. Document and keep a record of all daily and/or weekly audits, as per conditions #3 and #4, that includes the name of auditor and role, name of staff being audited and role, home area name/location, date and time of audit, any findings of audit and any corrective action taken if task was not completed as required. Provide the records immediately upon Inspector request.

6. Update the home’s PAN-Housekeeping Task Record, to ensure clear direction provided to housekeeping staff on what is required to be cleaned and disinfected during contact surface and/or resident room cleaning and frequency in the outbreak home area. Update the record to ensure that all required housekeeping

tasks during an outbreak have a section for staff to document these tasks upon completion.

**Grounds**
The licensee has failed to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a Medical Officer of Health appointed under the Health Protection and Promotion Act are followed in the home.

Specifically, the Ontario Ministry of Health's "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", effective April 2024, s. 5.12-Enhanced Environmental Cleaning and Disinfection, during a confirmed COVID-19 Outbreak, which states the cleaning and disinfecting of: Common areas at least once daily for low touch surfaces (shelving, windowsills, white/message boards; Minimum twice daily, for high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas; immediately for any visibly dirty surfaces; surfaces and items in close proximity to vulnerable resident populations require more frequent cleaning and disinfection than surfaces in close proximity to those who are less vulnerable. Additionally, cleaning and disinfection practices should be conducted twice daily, at minimum.

**Rationale and Summary:**

The Inspector conducted a mandatory IPAC inspection, in accordance with IPAC Checklist. Review of IPAC Lead's Outbreak Line List confirmed that the home declared an outbreak.

The Housekeeper, ESS, and ESM confirmed that during a confirmed outbreak one

housekeeper was assigned to each RHA, the floor housekeeper was to be co-horted to the outbreak home area and responsible for housekeeping tasks on the outbreak home area only. The ESS further confirmed that during an outbreak, the co-horted housekeepers was required to complete a deep clean daily of pre-assigned resident rooms and then "police" the other resident rooms, which did not include a deep cleaning or contact surfaces cleaning. The ESS was unable to confirm if housekeeping staff were responsible for cleaning and disinfecting all resident rooms in an outbreak home area.

The Housekeeper, ESS, and the Scheduler's confirmed that for three consecutive days on two Resident Home Areas, there was a confirmed disease outbreak and these two home areas had housekeeping shortages that the home was unable to fill.

The Housekeeper confirmed that they were working during these three consecutive days during the outbreak period. The housekeeper confirmed that they were not co-horted to work on the home area in outbreak and thus responsible for all housekeeping tasks for both home areas on both floors, including cleaning and disinfecting contact surfaces throughout the home area and resident rooms, twice daily.

The Housekeeper and ESS confirmed that housekeeping staff were to document tasks, upon completion, on the home's Housekeeping Task Record.

The home's Housekeeping Task Record for one RHA during a twelve-day period confirmed missing documentation for the required housekeeping tasks as follow: One day the first and second touchpoint cleaning, Two days first and second touchpoint cleaning, extra touch point cleaning for dining room tables/chairs, alcoves, activity rooms, and pre-assigned resident rooms.

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The Housekeeper confirmed that there was missing documentation because they did not complete the required housekeeping tasks during their shifts for three consecutive days. The Housekeeper confirmed that they were unable to complete the required housekeeping tasks due to a staffing shortage and that the touchpoint cleaner on shift was not redeployed.

The ESS confirmed that, during a confirmed outbreak and staffing shortage, it was unlikely that one housekeeper would be able to complete the required twice daily cleaning and disinfecting of contact surfaces throughout the outbreak home area and the pre-assigned resident rooms when responsible for two home areas.

The Schedulers, ESS, and ESM, all confirmed that other housekeeping roles, were on shift for three consecutive days during the outbreak period and that should have been redeployed to assist with the housekeeping shortages and were not.

Failure to ensure, during a confirmed disease outbreak, that cleaning and disinfecting practices were conducted, at minimum, twice daily, in accordance with "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", has placed residents at increased risk for disease transmission and prolonged disease outbreak.

**Sources:** Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings-Section 5.12 Enhanced Environmental Cleaning and Disinfection during a confirmed COVID-19 Outbreak, IPAC Lead's Outbreak Line List, Outbreak Housekeeping Task Record, Interviews with Staff, ESS, and ESM.

**This order must be complied with by** February 7, 2025.

## NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
O. Reg. 246/22 - s. 78 (6) (b) - food production, institutional food service equipment - Compliance Order #009 - under Inspection Report #2024_1544_0001 - CDD July 5, 2024.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

## 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.