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)

Amended Report Issue Date: February 4, 2025
Original Report Issue Date: January 17, 2025
Inspection Number: 2025-1498-0001 (A1)
Inspection Type: Complaint Critical Incident Follow up
Licensee: Royal Canadian Legion District 'D' Care Centres
Long Term Care Home and City: Tony Stacey Centre for Veterans' Care, Toronto

AMENDED INSPECTION SUMMARY

This report has been amended to:

- Change CO #001's compliance due date from April 11, 2025, to April 28, 2025, as per the home's request.
- Update CO #001's ground to reflect IPAC standard 5.4(a) instead of 5.4(b).
- Change CO #002's compliance due date from April 11, 2025, to April 28, 2025, as per the home's request.
- Modify CO #003's second condition to allow the home additional time to provide a copy of their action plan to the inspector by February 28, 2025, as per the home's request.

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- Modify CO #003's second condition to allow the home additional time to provide a copy of their action plan to the inspector by February 28, 2025, as per the home's request.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-10, 13-17, 2025.

The following intake(s) were inspected:

- Intake: #00108505, Intake: #00116780, and Intake: #00118733 - related to missing residents.
- Intake: #00128392 – Complaint related to housekeeping, food temperatures, allegations of abuse and skin and wound.
- Intake: #00130028 – related to disease outbreak.
- Intake: #00130282 - Follow-up #2 - FLTCA, 2021 s. 19 (1) (c), CDD September 30, 2024.
- Intake: #00130283 - Follow-up #1 - O. Reg. 246/22 s. 102 (15) 2, CDD November 25, 2024
- Intake: #00130284 - Follow-up #1 - O. Reg. 246/22 s. 97, CDD December 16, 2024
- Intake: #00131583 – Complaint related to fluid consistency.

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2024-1498-0004 related to O. Reg. 246/22, s. 102 (15) 2. inspected by the inspector.

Order #001 from Inspection #2024-1498-0004 related to O. Reg. 246/22, s. 97 inspected by the inspector.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #002 from Inspection #2024-1498-0001 related to FLTCA, 2021, s. 19 (1) (c) inspected by the inspector.

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

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship,

creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident's rights were treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth, and individuality were respected and promoted when a Registered Practical Nurse (RPN) picked up a medication pill from the floor and intended to administer it to the resident.

Sources: Observation and interview with the RPN.

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

During a tour of the home, a nourishment cart was seen propping open a door, next to a nursing station.

A resident was observed ingesting items on the nourishment cart. A Personal Support Worker (PSW) confirmed the cart is required to be placed in an area that residents cannot access.

Sources: Observations, the resident's clinical records and interview with the PSW.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident was seen ingesting items found on a nourishment cart. The home's Registered Dietitian (RD) indicated that the resident was not permitted to ingest cookies found on the nourishment cart.

Sources: Observations, the resident's clinical records, interview with the RD.

WRITTEN NOTIFICATION: Conditions of licence

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

CO #002, condition 5. from #2024-1498-0001 issued on June 24, 2024, with a compliance due date of September 30, 2024, to FLTCA, 2021 s. 19 (1) (c), Accommodation Services, was not complied with.

The following components of the order were not complied:
5. Ensure that all repairs to flooring, walls, tiles in showers, drywall, concrete, and

surfaces requiring painting are completed.

Sources: Observations of first and second floor resident home areas, documents Compliance Plan for 5 Compliance Orders and Ministry Compliance (inspection report) Action planning, Preventive Maintenance Policy, 03-02-03, with a last revision date of August 2024 and interview with Environmental Services Manager (ESM) and Administrator.

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Inspection #2024-1498-0004 - Written Notification and Administrative Monetary Penalty issued October 24, 2024.

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

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

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the food is being served at a temperature that was both safe and palatable to the residents when the food temperatures were not consistently recorded and dated before serving meals to residents.

Source: Point of Service Temperature Records, Food Temperature Logs and Taking Temperature policy, and interview with the Food Services Manager (FSM).

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (5)
Infection prevention and control program
s. 102 (5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;
(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology. O. Reg. 246/22, s. 102 (5).

The licensee has failed to ensure that their Infection Prevention and Control (IPAC) lead had the required education and experience upon starting the position on October 23, 2024. The IPAC lead confirmed they had not completed the required IPAC education before assuming the temporary IPAC lead role on Oct 23, 2024.

Sources: IPAC lead orientation checklist and interview with the IPAC lead.

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (10) (a)
Emergency plans
s. 268 (10) The licensee shall,
(a) on an annual basis test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies, violent outbursts, gas leaks, natural disasters, extreme weather events, boil water advisories, outbreaks of a communicable disease, outbreaks of a disease of public health significance, epidemics, pandemics and floods, including the arrangements with the entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the Connecting Care Act, 2019, partner facilities and resources that will be involved in responding to the emergency;

The licensee failed to ensure that, on an annual basis, their emergency plans related to situations involving a missing resident was tested.

Sources: Interview with the Director of Care.

(A1)
The following non-compliance(s) has been amended: NC #008

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 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)]:

1. The Infection Prevention and Control (IPAC) Lead or designate shall provide an in-person education to a PSW focusing on PPE donning and doffing when additional precautions are in place. Keep a documented record of who provided the education, the date of the education provided, and the contents of the education.
2. The IPAC lead or designate shall conduct weekly audits on the PSW to observe five different instances of donning and doffing PPE, per week. PSW #101 shall be observed entering a resident room who are on droplet and contact precautions to validate adherence of appropriate use of PPE. Audits are to be completed for a total of three consecutive weeks. Audit documentation must include the name of the auditor, the date and time of the audit, room number, and any corrective actions taken for identified non-compliance.
3. The IPAC Lead or designate shall provide an in-person education to two RPNs focusing on the home's outbreak management protocols, additional IPAC requirements including PPE usage during suspected or confirmed outbreaks. Keep a documented record of who provided the education, the date of the education provided, and the contents of the education.
4. The IPAC lead or designate shall conduct audits on the two RPNs to observe each RPN five different instances during a respiratory outbreak or when the RPNs entering a resident room who are on droplet and contact precautions to validate adherence of appropriate use of PPE. Audits are to be completed for three weeks. Audit documentation must include the name of the auditor, the date and time of the audit, name of the staff, room number if applicable, and any corrective actions taken

for identified non-compliance.
5. The Director of Care (DOC) or designate shall develop a written process to ensure that the home's IPAC program includes all the policies and procedures that are required under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023).
6. The IPAC lead or designate shall provide an in-person education to all staff in the home who administer medications to residents focusing on the home's policies and procedures of the IPAC program that address IPAC practices related to safe administration and handling of medications. Keep a documented record of who provided the education, staff names who received the education, the date of the education provided, and the contents of the education.
7. The IPAC Lead or designate shall provide education to all registered staff assigned to the first floor, on when appropriate precaution signage is to be posted and removed for residents on additional precautions.
8. Document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that completed the education session.
9. The IPAC Lead or designate shall develop an audit sheet and use this audit sheet to conduct daily audits of the first floor, over the course of four weeks. This is to ensure that residents on additional precautions have the appropriate signage posted or removed. The daily audit sheet will contain the individual completing the audit, rooms requiring additional precautions signage, corrective actions taken if additional precautions signage is not posted or removed and any the names of staff if education was provided.
10. All audits and education records will be retained and made available to inspectors upon request.

Grounds

1- The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure evidence-based practices related to potential droplet transmission and required precautions were followed when a PSW didn't wear a face shield, wore double gloves, and didn't perform hand hygiene as required.

Sources: Observation and interview with the PSW.

2- The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 6.7 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), Masks are required based on relevant guidance in place at any time.

A facility-wide outbreak of acute respiratory illness was declared, with directives from the public health unit mandating masking throughout the facility.

During the outbreak, a Registered Practical Nurse (RPN) was observed without a face mask in the second-floor nursing station and the corridor of the south unit.

During the outbreak, two RPNs were observed without a face mask in the second-floor nursing station.

The RPNs confirmed they were not wearing their face masks and acknowledged

the requirement to do so.

Failure to adhere to mandatory masking protocols during a respiratory outbreak significantly increases the risk of infection transmission among residents and staff.

Sources: Observation and interview with the RPNs.

3- The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 5.4 (a) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that the policies and procedures for the IPAC program specifically address IPAC practices related to safe administration and handling of medications.

Director of Care (DOC) confirmed that the home doesn't have policies and procedures for the IPAC program that specifically address IPAC practices related to the safe administration and handling of medications.

The absence of policies and procedures within the IPAC program addressing the safe administration and handling of medications significantly increases the risk of infection transmission among residents and staff.

Sources: interview with the DOC.

4- The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was implemented. Specifically, the licensee failed to ensure that appropriate signage was posted to indicate residents were on additional precautions.

The home failed to ensure that section 9.1 e) of the IPAC Standard for Long-Term Care Homes April 2022, revised in September 2023 was met.

During a respiratory outbreak, a resident's room who was under additional precautions was observed without a posted additional precautions signage.

Sources: Observations and the resident clinical records.

This order must be complied with by April 28, 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 #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:
Inspection #2024-1498-0001 - Compliance Order issued June 24, 2024.

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.

(A1)
The following non-compliance(s) has been amended: NC #009

COMPLIANCE ORDER CO #002 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 (11)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

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 the Infection Prevention and Control (IPAC) lead or designates shall develop a written process in collaboration with their local Public Health Unit (PHU) to ensure prompt testing and reporting of infectious cases to their local PHU.
2. The DOC or designate shall provide an in-person education to all management staff focusing on the home's emergency preparedness plan related to pandemic, epidemic and outbreak plan, the home's outbreak management policies, and the developed written process regarding the reporting of infectious cases to their local PHU. Keep a documented record of who provided the education, the date of the education provided, and the contents of the education.
3. The DOC or designate shall conduct daily audits to ensure that infectious residents are tested and reported to the local PHU as per the protocols. Audits are to be completed for six weeks. Audit documentation must include the name of the auditor, the date and time of the audit, resident's name and room, the date and time of the reporting to the local PHU, the method of communication with the local PHU, and any corrective actions taken for identified non-compliance.
4. All audits and education records will be retained and made available to inspectors upon request.

Grounds

The licensee has failed to ensure that the home complied with the outbreak management system, as set out in Ontario Regulation (O. Reg. 246/22) 102 (11).

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure

that written policies and protocols that were developed for the outbreak management system were complied with. Specifically, staff did not comply with the licensee's policy related to reporting infectious residents and declaring an outbreak.

A suspect respiratory outbreak on Tony Stacey's first floor was declared by the Public Health Unit (PHU) on a specific date. Mandatory masking on the first floor, staff cohorting, and staff and resident distancing was put in place.

A confirmed Respiratory outbreak facility-wide was declared on the next day. Mandatory masking facility-wide and staff and resident distancing were put in place.

A line list that was provided to the inspector showed 20 residents with infectious symptoms.

Director of Care (DOC) and a Public Health Nurse (PHN) confirmed that the home didn't report any infectious residents to the PHU before the date the suspect outbreak was declared.

The DOC confirmed that the home didn't report infectious residents to the local PHU as per the home's Emergency Preparedness Plan and the Outbreak Management - Respiratory (Except COVID-19) (LTC) policy.

The PHN confirmed that the home failed to report infectious residents to the PHU as per protocol. They added that the home should have reported residents with infectious symptoms to the PHU as soon as they became aware of the infectious symptoms.

The DOC acknowledged that as per the home's Outbreak Management - Respiratory (Except COVID-19) (LTC) policy, the suspect outbreak should have been

declared either four or nine days earlier.

The PHN confirmed that based on the information that they received from the home, and if the information was available on the date that was listed on the line list, a suspect outbreak would have been declared 9 days earlier, and initial control measures put in place at that time.

A record review of the line list and Public Health Laboratory results of residents' nasopharyngeal swabs revealed that the first positive nasopharyngeal swab was reported to the home 4 days before the suspect outbreak. Nasopharyngeal swabs were collected from two residents after four days after their symptoms onset; these two residents were positive for Influenza A.

The home's Outbreak Management - Respiratory (Except COVID-19) (LTC) policy stated that nasopharyngeal swabs should be collected from residents early in the course of their acute symptoms, within the preceding 48 hours.

The PHN confirmed that the home failed to test residents using laboratory methods as soon as symptoms were present.

Failure to follow the licensee's policies for reporting, declaring an outbreak, testing, and promptly implementing initial control measures placed residents at increased risk of exposure to infectious agents.

Sources: Critical Incident Report (CIR), Tony Stacey's Emergency Preparedness Plan, Outbreak Management - Respiratory (Except COVID-19) (LTC) policy (PolicyStat ID 16713461, Last Revised 09/2024), interview with DOC #102 and PHN #117. [741724]

This order must be complied with by April 28, 2025

(A1)

The following non-compliance(s) has been amended: NC #010

COMPLIANCE ORDER CO #003 Accommodation services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (1) (c)
Accommodation services
s. 19 (1) Every licensee of a long-term care home shall ensure that,
(c) there is an organized program of maintenance services for the home.

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

1. The Environmental Service Manager (ESM) or designate will develop a tool or method to evaluate the state of repair of all resident home areas, including but not limited to corridors, resident rooms, resident washrooms, shower rooms, dining areas, and activity rooms.
2. Once areas requiring maintenance services have been identified, such as light fixtures, windows, walls, baseboards, floors, handrails, countertops, and furnishings, the home must:

- Develop an action plan categorizing the identified items into three groups:
    - Items that can be repaired immediately.
    - Items that can be repaired within 1-4 weeks.
    - Items requiring more than 4 weeks to repair.
- Specify in the action plan the individual responsible for each maintenance service, the expected completion date, the method for completing the repair,

the status of the repair, the date of completion, and how it will be maintained over time.

- Upon completing the action plan, please provide a copy to the inspector via an email by February 28, 2025.
- Please ensure that the action plan does not contain any PI/PHI.

3. Ensure that management in the home, including the Administrator, Director of Care, IPAC lead, and ESM, actively participate in the development and implementation of the action plan.

4. Conduct a review of the preventive maintenance program to ensure it includes regular audits verifying that maintenance in the home and its furnishings are kept in a state of good repair. Keep a record of the review, including the participants, the date of the review, and any changes made to the program.

5. Keep a record of all documents including quotes, contracts, preventative maintenance program records, and the action plan and make them available to inspectors upon request.

Grounds

The licensee has failed to ensure maintenance services in the home are maintained in good repair.

During a tour of the home, multiple resident home areas required maintenance, including light fixtures, windows, handrails, uneven flooring, damages to baseboards and walls in resident washrooms and bedrooms. When speaking with the home's Environment Services Manager (ESM), they indicated they were aware of some of

the areas requiring repair and repainting, however, were not able to provide an anticipated date of completion.

Sources: Observations of first and second floor resident home areas, documents Compliance Plan for 5 Compliance Orders and Ministry Compliance (inspection report) Action planning, Preventive Maintenance Policy, 03-02-03, with a last revision date of August 2024 and interview with ESM.

This order must be complied with by May 30, 2025

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 $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Inspection #2024-1498-0001 - Compliance Order High Priority issued June 24, 2024.

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.

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.
Follow-up #2 was inspected for one of the previous orders

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.