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

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

**Report Issue Date:** February 20, 2024

**Inspection Number:** 2023-1287-0005

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** CVH (No. 4) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

**Long Term Care Home and City:** Pinecrest (Plantagenet), Plantagenet

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Joelle Taillefer (211) | Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2024.02.27 18:44:05 -05'00' |

**Additional Inspector(s)**
Manon Nighbor (755)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 19, 2024 (onsite), and January 23, 2024 (offsite).

**The following intake(s) were inspected:**
**Complaint:**

- Intake: #00099493 - related to an allegation of physical abuse from resident to resident, medication management, safe and secure home, and reporting and complaints.
- Intake: #00103067 - related to safe and secure home, infection prevention and control, and prevention of abuse and neglect.

**Critical Incident Report (CIS)**

- Intake: #00100418 - related to falls prevention and incident that causes an injury to a resident which resulted in a significant change in the resident's health status.
- Intake: #00100649 - related to an allegation of physical abuse from resident to resident and responsive behaviour.
- Intake: #00101970 – related to a follow-up regarding infection prevention and control.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1287-0004 related to FLTCA, 2021, s. 184 (3) inspected by Joelle Taillefer (211)

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

Resident Care and Support Services
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's provision of care that was set out in the plan of care related to safety regarding two responsive behaviours that indicated to check the resident's whereabouts every 15 minutes was documented in the task's intervention.

**Rationale and Summary:**
On a date in 2023, a resident's progress notes indicated that the resident was exhibiting a specific responsive behaviour in the hallways and observed shaking a door handle on five occasions.

The next day, the resident's progress notes indicated that the resident followed another family member outside without a coat. The resident went around the corner and began to come back as it was too cold outside.

Twenty-six days later, the resident's progress notes indicated that the resident went out the main door when the evening staff opened the door. The resident was immediately redirected back inside the home. The progress notes indicated that the resident would continue to be monitored.

The resident's current plan of care indicated that the resident had three identified responsive behaviours. The interventions are to monitor the resident every 15 minutes and to document in Point of Care (POC).

Inspector #211 reviewed the resident's "Documentation Survey Report" for two specific months, and it was noted that there was no documentation related to Safety regarding the two identified responsive behaviours that specified to check resident's whereabouts every 15 minutes and as needed to ensure residents safety for several dates and times.

A Registered Nursing Staff stated that the main front entrance door was always locked and can be opened only by pressing the code numbers on the secure door keypad which the number is kept confidential. The Registered Nursing Staff stated that they presumed that it was a family member who let the resident exit the home on the identified date.

Another Registered Nursing Staff stated not seeing the resident going outside on the identified date, as at the time they were charting. The Registered Nursing Staff stated they received a phone call and then heard someone screaming that a resident was outside. The Registered Nursing Staff believed the resident followed a family member exiting the home as overhearing a family member saying that they let the resident go outside.

As the staff members did not document the whereabouts of the resident in the home every 15 minutes as indicated in resident's plan of care, there is a potential risk that the resident could exit the home.

**Sources:** A resident's health care records and interviews with two Registered Nursing Staff.

[211]

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

**Rationale and Summary:**
On a date in 2023, a resident had a fall. They sustained an injury and returned to the home from the hospital five days later.

Nine days later, the resident's plan of care stated that the use of an electronic prompt such as two identified devices was one the resident's fall prevention intervention.

During the inspection, the inspector did not observe the two identified devices put in place as a fall prevention intervention for the resident.

A Registered Nursing Staff stated that resident does not need the two identified devices, since they do not get out of their chair.

As such, the written plan of care was not revised after the resident care needs changed and the care set out was no longer necessary.

**Sources:** A resident's health record, observation and interview with a staff member. [755]

## WRITTEN NOTIFICATION: Air Temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 24 (1)**
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

**Rationale and Summary:**
Review of the licensee "Humidex Heat Stress Response Plan Log" temperature sheets from November 13, 2023, to January 7, 2024, indicated that some identified resident bedrooms were not maintained at a minimum temperature of 22 degrees Celsius for several dates during the morning, every afternoon between 12 p.m and 5 p.m and during the evening or night.

On an identified date in 2024, a staff member and Inspector #211 observed various areas in the home where the temperatures were not maintained at a minimum of 22 degrees Celsius as follows:
-At 1307 hours, in two resident's rooms from an identified wing, the activity room,

the dining room, and at the beginning of the east wing hallway toward the front entrance.
-At 1454 hours, in five resident's rooms from an identified wing, the activity room, the dining room, the north wing hallway and the front entrance.

The next day, from 1100 hours to 1115 hours, a staff member and Inspector #211 observed various areas in the home where the temperatures were not maintained at a minimum temperature of 22 degrees Celsius in three resident's rooms from an identified wing, the activity room, the dining room, and the front entrance.

The Executive Director stated that the temperatures documented on the licensee "Humidex Heat Stress Response Plan Log" from November 13, 2023, to January 7, 2024, were recorded correctly.

The Executive Director stated that one of the roof top heating units that served the common areas (activity room, dining room and front entrance) has been out of order since May 2023.

As such, the residents were potentially uncomfortable when the temperature was not maintained at a minimum temperature of 22 degrees Celsius.

**Sources:** Review of the licensee "Humidex Heat Stress Response Plan Log" temperature sheets, a staff member and Inspector #211's observation of temperatures in various areas, and interview with the Executive Director.
[211]

## WRITTEN NOTIFICATION: Air Temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 24 (3)**
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature was measured and documented in writing, in one resident common area on every floor of the home, which may include a lounge, dining area or corridor at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**Rationale and Summary:**
Review of the temperature sheet titled "Humidex Heat Stress Response Plan Log" from November 13, 2023, to January 7, 2024, indicated that one resident common area on every floor of the home, which may include a lounge, dining area or corridor was not documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, except January 4, and 5, 2024, in the afternoon between 12 p.m. and 5 p.m.

During the inspection, Inspector #211 observed that the activity room was being used as a dining room.

On an identified date, a resident stated that the activity room was cold today and yesterday. Another resident stated that the activity room was cold for the past two weeks. Two other residents stated that the activity room was cold. Another resident stated that there were days when the temperature in the dining room was cold depending on how cold the temperature was outside.

The Executive Director (ED) stated that their process to document the temperatures

in writing needed to be revised since one resident common area has not been measured and documented once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**Sources:** Review of the licensee "Humidex Heat Stress Response Plan Log" temperature sheets, a staff member and Inspector #211's observation of temperatures in various areas, and interviews with the Executive Director and residents.
[211]

## WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.**
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that the pain management program must, at a minimum, provide monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

**Rationale and Summary:**
On a date in 2023, a resident had a fall. The resident sustained an injury and returned to the home from the hospital five days later.

Between two identified dates in 2023, on three separate occasions, the resident was

administered a medication for their pain and the residents' responses to, and the effectiveness of, the pain medication was not indicated.

On a date in 2024, a Registered Nursing Staff and then the DOC on the next day, both confirmed that the medication's effectiveness should have been found in the electronic medication administration record (EMAR), which would have auto populated in the progress notes, and this was not completed.

As such, the resident was at risk of potentially not having their pain effectively monitored and managed.

**Sources:** Resident's related health record and interviews with staff members. [755]

## WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 57 (2)**
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

**Rationale and Summary:**
On a date in 2023, a resident had a fall. The resident sustained an injury and

returned to the home from the hospital five days later.

Eight days later, an identified medication was administered for the resident's pain and it's effectiveness was evaluated and found to have been ineffective. There was no further action noted in the resident's health record.

The next day, another pain medication was administered, the effectiveness of the medication was evaluated and was found ineffective. There was no further action noted in the resident's health record.

The Director of Care (DOC) stated that the medication's effectiveness should have been documented and a pain assessment should have been completed. There was no pain assessment found in the resident's health record on these specific dates. On the same day, a Registered Nursing Staff said that the medication's effectiveness should have been documented.

As such, there was no pain assessment completed after the pain medications were found ineffective, which makes it difficult to determine if another pain strategy or intervention was implemented to manage the resident's pain.

**Sources:** resident's related health record, interviews with the DOC and a Registered Nursing Staff.
[755]

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to document a resident's responsive behaviours and the resident's response to the interventions.

**Rationale and Summary:**
A resident's current plan of care demonstrated the resident had identified responsive behaviours.

On a date in 2023, the attending physician documented that the resident's identified responsive behaviours increased and there was occasional retaliation".

Forty-seven days later, the resident's progress notes indicated that an identified resident had a specific responsive behaviour towards the resident and the aggression was stopped by an individual.

The resident's "Documentation Survey Report" initiated on a date in 2023, indicated to document the resident's responsive behaviours every 30 minutes. The resident's "Documentation Survey Report" staff member did not have documentation entries for several days and times on a month in 2023.

A Registered Nursing Staff stated being informed by an identified individual on a date in 2023, that they prevented an identified resident from exhibiting a potential harmful interaction toward the resident.

As such, the resident's responsive behaviours and responses to interventions were not documented in the "Documentation Survey Report" to monitor the resident's responsive behaviours every 30 minutes..

**Sources:** An identified resident's progress notes, another resident's plan of care and "Documentation Survey Report" for a month in 2023 and interview with a Registered Nursing Staff.
[211]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 licensee has failed to ensure to implement any standard issued by the Director with respect to infection prevention and control.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes revised in 2023, the additional requirement under the 10.4 (h), indicated that the licensee shall ensure to support residents to perform hand hygiene prior to receiving meals.

**Rationale and Summary:**
On a date in 2024, Inspector #211 observed a staff member bringing a resident in

their wheelchair into the dining room. Inspector #211 did not observe that the resident's hands were cleaned and disinfected prior to their meal.

The staff member confirmed that the resident's hands were not cleaned and disinfected prior to their meal.

As such there was a potential risk to residents' health and safety as the resident's hands were not cleaned and disinfected prior to their meal on a date in 2024.

**Sources:** Inspector #211's observation and interview with a staff member.
[211]

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

**Rationale and Summary:**
Review of the Critical Incident Report submitted on January 15, 2024, indicated that the outbreak of the Acute Respiratory Infective Disease (ARI) for Influenza A was declared on January 14, 2024.

On January 11, 2024, Inspector #211 was informed by the Infection Prevention and Control (IPAC) Regional Specialist that the home was presently declared in Respiratory Outbreak.

On January 15, 2024, the IPAC Regional Specialist stated being informed that the respiratory outbreak was related to Influenza A.

The Executive Director confirmed that the Director was not immediately informed that the home was declared in respiratory outbreak on January 11, 2024.

As such, there was a risk that the outbreak could not be tracked by the Director when the home was declared in respiratory outbreak on January 11, 2024.

**Sources:** Review of the Critical Incident Report. Interview with the IPAC Regional Specialist and the Executive Director.
[211]

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.**
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the

incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee has failed to ensure that the Director was informed as per subsection 5, no later than one business day when a resident was missing for less than three hours and who returned to the home with no injury or adverse change of condition.

**Rationale and Summary:**
On a date in 2023, a resident's progress notes indicated that the resident was exhibiting an identified responsive behaviour in the hallways and observed shaking the exit door handles on five occasions.

The next day, the resident's progress notes indicated that the resident followed another family member outside without a coat. The resident went around the corner and began to come back as it was too cold outside.

A Registered Nursing Staff stated that a staff member informed an identified Registered Nursing Staff on a date in 2023, that a resident was seen outside from a window. The resident was situated at the corner of the home in the parking area. The Registered Nursing Staff stated when the resident was found outside, the resident was returning to the front main entrance door informing an identified Registered Nursing Staff that it was too cold outside. The Registered Nursing Staff stated that the front door was always locked and can be opened only by pressing the code numbers on the secure door keypad which the number is kept confidential. The Registered Nursing Staff stated that the identified Registered Nursing Staff did inform the Executive Director. They presume that it was a family member who let the resident exit the home.

The identified Registered Nursing Staff stated observing the resident in the home 5 minutes prior to being informed that the resident was found outside on a date in 2023.

The Executive Director confirmed being informed that the resident was found by staff members outside on a date in 2023, and the Director was not informed of the incident.

As such, the Executive Director did not inform the Director no later than one business day after the resident was found outside for less than three hours and who returned to the home with no injury or adverse change in condition on a date in 2023.

Sources: A resident's health care records and interviews with Registered Nursing Staff and the Executive Director.
[211]

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.**
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

The licensee has failed to ensure that the Director was informed no later than one business day when one of the three roof top heating systems that served the common areas has been out of order since May 2023, that affected the well-being of one or more residents for a period greater than six hours.

**Rationale and Summary:**
Over the course of this inspection, it was determined that one of the roof top heating units that served the common areas has been out of order since May 2023.

On May 10, 2023, the "Thermogenics Intelligent Steam" Service Report indicated that the three roof top units "TRANE heating exchanger" were inspected. The report indicated that one of the roof top heating exchanger units was defective.

The Environmental Services Manager stated that the roof top unit "TRANE Heating Exchanger" that was defective was the heating system providing heat to the activity room, the dining room, and the front entrance.

On January 4, 2024, at 1454 hours, and January 5, 2024, at 1100 hours, Inspector #211 accompanied a staff member as they measured air temperature in the activity room, the dining room, and the front entrance which were noted to be below 22 degrees Celsius. The failure to maintain the home at a minimum of 22 degrees Celsius is further described in the written notification #003.

The Executive Director (ED) stated that after it was discovered in May 2023, that one of the roof top heating exchanger units was defective and needed replacement parts, they were informed that those replacement parts will take 50 to 52 weeks to receive them. The ED confirmed that the Director was not informed that one of the three roof top heating systems was out of order since May 10, 2023.

As such, the Director was not informed no later than one business day, when one of the three roof top heating systems that served the common areas was out of order since May 10, 2023, that affected the well-being of residents.

**Sources:** Review of the "Thermogenics Intelligent Steam" Service Report. A Staff member and Inspector #211 observation of temperatures in resident's common areas and interview with the Environmental Services Manager and the Executive Director.
[211]

## COMPLIANCE ORDER CO #001 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 6 (11) (b)**
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

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

A) Complete weekly reassessments for a resident's responsive behaviours and the effectiveness of the interventions in the resident's plan of care to prevent verbal and physical altercations and harmful interactions with other residents.
B) When the interventions for responsive behaviours in the resident's plan of care are not effective, consider different approaches to adjust the interventions so that

they are effective.
C) A written record must be kept of everything required under (A) and (B) until the order is complied.

**Grounds**
The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when a resident's plan of care was reviewed and revised, and the care set out in the plan was not effective.

**Rationale and Summary:**
A resident's care plan revised on a date in 2023, indicated that the resident had several identified responsive behaviours.

On a date in 2023, the resident's progress notes indicated that a staff member heard the resident yelling from their room and found another resident standing in the middle of the room. The resident alleged abuse by the identified resident. The incident was not witnessed by a staff member. The resident's progress notes indicated that there was no altered skin integrity to the resident's skin area. The identified resident was returned to their room.

Eight days later, a second identified resident's progress notes indicated that the identified resident had attempted responsive behaviour towards the resident. A staff member separated both residents.

The next day, the resident and the second above identified resident's progress notes indicated that the identified resident exhibited responsive behaviour towards the resident. A staff member separated the other resident from the resident. The identified resident was redirected.

Two days later, the physician documented that the resident had specific responsive behaviours and there was occasional retaliation". Resident was seen by a specialized physician related to the resident's responsive behaviours who suggested adding an identified medication and to increase the dose slowly. The progress notes indicated that the resident's medications were revised and adjusted to control the resident's responsive behaviours.

Ten days later in 2023, the resident's progress notes indicated that the resident had a specific responsive behaviour in the hallways and the front lobby and exhibited another specific responsive behaviour at everyone around or passing nearby. Approximately three hours later, the resident exhibited another identified responsive behaviours towards other residents.

Several days later, the resident and another third resident's progress notes indicated that the residents were exhibiting responsive behaviours towards each other. At the same time, the resident's progress notes indicated that the resident was having a specific type of altercation with another resident. The residents were separated by two Registered Nursing Staff.

Several days later in 2023, the above second identified resident's progress notes indicated that the resident attempted exhibiting responsive behaviour towards the resident and the responsive behaviour was stopped by an identified individual. The above second identified resident was redirected to the nursing station and monitored every thirty minutes to detect further episodes of responsive behaviours.

Four days later, the resident was agitated and was picking an argument with another (third above) resident.

Review of the resident's health care records for the past two months in 2023,

indicated that the resident's responsive behaviours were followed by the attending physician, Behavioural Supports Ontario (BSO), and another specialized physician. Furthermore, the resident's "Documentation Survey Report" indicated that the resident's responsive behaviours were to be monitor every 30 minutes and was initiated and implemented at approximately 8 weeks later in 2023.

The Executive Director stated that the resident was transferred to another room on an identified date in 2023, to prevent altercations between the resident and another resident.

As such, the licensee did not consider other different approaches when the resident's care set out in the plan of care had not been effective to prevent potential harmful interactions with other residents on three identified dates prior being transferred to another room. The resident was transferred to another room on a date in, 2023, where the resident continued to exhibit potential harmful interactions on two other dates. Consequently, there is a potential risk of further harmful interactions between the resident and other residents.

**Sources:** Three identified residents' health care records, and interview with the Executive Director.
[211]

**This order must be complied with by** April 19, 2024

## 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.