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: December 23, 2024
Original Report Issue Date: October 4, 2024
Inspection Number: 2024-1218-0004 (A1)
Inspection Type: Critical Incident Follow Up
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough

AMENDED INSPECTION SUMMARY

This report has been amended to:

Include RIF, and associated AMP, pursuant to FLTCA, 2021, s. 104 (4), related to Follow Up #1, Compliance Order #001, related to O. Reg. 246/22, s. 12 (1) 3, under IR #2024 1218 0002. CDD September 13, 2024.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19, 20, 23-27, 2024

The following intake(s) were inspected:

- An intake related to Follow-up #: 1 - Compliance Order (CO), O. Reg. 246/22 - s. 79 (1) 4., Dining and Snack Service.

- An intake related to CO Follow-up # 2, O. Reg. 246/22 - s. 79 (1) 5., Dining and Snack Service, Written Notification with FLTCA, 2021, s. 104 (4) Conditions of Licence #3 and #4 of CO #002.
- An intake related to CO Follow-up #: 1, O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control.
- An intake related to CO Follow-up # 1 - CO #001/2024-1218-0002, O. Reg. 246/22 - s. 12 (1) 3., Doors In A Home.
- An intake related to CO Follow-up # 2, O. Reg. 246/22 - s. 79 (1) 8., Dining and Snack Service. Written Notification with FLTCA, 2021, s. 104 (4) Conditions of Licence #4 of CO #003.
- An intake related to a suspected abuse incident.

Previously Issued Compliance Order(s)

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

Order #002 from Inspection #2024-1218-0002 related to O. Reg. 246/22, s. 79 (1) 4. inspected by the Inspector.

Order #002 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 79 (1) 5. inspected by the Inspector.

Order #003 from Inspection #2024-1218-0002 related to O. Reg. 246/22, s. 102 (2) (b), inspected by the Inspector.

Order #003 from Inspection #2024-1218-0001 related to O. Reg. 246/22, s. 79 (1) 8, inspected by the Inspector.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1218-0002 related to O. Reg. 246/22, s. 12 (1) 3. inspected by the Inspector.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure a resident was afforded the right to be free from

abuse.

Rationale and Summary

The licensee submitted a Critical Incident (CI) to the Director regarding suspected abuse of a resident by another resident.

The licensee's policy, 'Zero Tolerance of Abuse and Neglect of Residents' indicated that every resident has the right to be free from abuse.

The clinical health record for the resident was reviewed. Documentation identified the resident as a vulnerable individual and was dependent on staff for all activities of daily living. Documentation identified a Personal Support Worker (PSW) who heard the resident calling for assistance; the PSW and Registered Nurse (RN) arrived to find the resident lying in their bed with injuries. Documentation identified the resident indicated they were injured by another resident. Documentation identified the resident was assessed to have injuries, complaints of discomfort, was in distress following the incident. Documentation identified the resident's Substitute Decision Maker (SDM) had indicated the co-resident had been exhibited responsive behaviours towards the resident prior to the CI.

Behavioural Support-Registered Practical Nurse (BSO-RPN), two Registered Nurses, and the Director of Care (DOC) confirmed the altercation occurred and that the resident was injured by the co-resident. The BSO-RPN and the DOC indicated this was not the first occurrence where the co-resident had exhibited responsive behaviours towards others.

Failure of the licensee to ensure residents were afforded the right to be free from abuse resulted in harm to the resident and posed a continued risk to the safety and

well-being of the resident.

Sources: Review of the clinical health record for the residents, licensee's investigation, CI, licensee's policy, 'Zero Tolerance of Abuse and Neglect of Residents', and interviews with RNs, Behaviour Support Lead-RPN, DOC and the Administrator.

WRITTEN NOTIFICATION: Licensee must comply

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 failed to comply with condition #2 of a compliance order (CO), specifically CO #001, from Inspection #2024_1218_0002. The CO was pursuant to O. Reg. 246/22, s. 12 (1) 3. The compliance due date was identified as September 13, 2024.

Pursuant to O. Reg. 246/22, s. 12 (1) 3, all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to these areas by residents, and the doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary

Condition #2, of the CO identified that the licensee must:

Devise and implement a method of securing all doors into non-residential areas to

ensure that there is no access to those areas when unsupervised by staff.

On two specific days, the Inspector observed doors leading to a non-residential area propped open. and or ajar. The doors were observed to be equipped with keyless entry locks, and staff were not observed in attendance in these rooms.
Per part 2 of the condition of the CO, RPN, Environmental Services Manager (ESM), Maintenance Manager (MM), DOC, and the Administrator indicated that all doors leading to non-residential areas were to be closed and locked when staff are not in attendance.

Per part 2 of the condition of the CO, the DOC, and the Administrator confirmed that condition #2 of the order had not been met.

Failure to comply with all conditions of CO #001 posed gaps in care and services related to resident safety.

Sources: Observations; review of the licensee's evidence folder related to CO #001; and interviews with RPN, ESM, MM, Environmental Manager for OMNI Quality Living, DOC, and the Administrator.

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #
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, 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:
The licensee has been previously issued non-compliance pursuant to FLTCA, 2021, s. 104 (4) but such was NOT related to O. Reg. 246/22, s. 12 (1) 3.

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: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies that were developed to respond to a resident exhibiting responsive behaviours were implemented.

Rationale and Summary

A CI was submitted to the Director regarding the suspected abuse of a resident by a co-resident.

The clinical health record for the resident was reviewed. Documentation indicated the resident was known to exhibit responsive behaviours towards others. Documentation identified the triggers to the resident's behaviours, and developed interventions.

BSO-RPN and two RNs indicated being aware of the potential trigger for the resident's exhibited behaviours; and indicated such potentially contributed to the CI. BSO-RPN, two RNs, as well as the DOC, confirmed interventions developed had not been implemented prior to, and or following the CI.

Failure of the licensee to implement strategies that had been developed for a resident known to exhibit responsive behaviours posed a heightened risk to the safety and well-being of a resident and potentially contributed to the CI.

Sources: Review of the clinical health for the resident, CI, licensee's investigation; and interviews with BSO-RPN, RNs, and the DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure a resident who required assistance at meal service was safely positioned.

Rationale and Summary

During the inspection, a resident was observed, at mealtime, seated in a mobility device with the positioning mechanism engaged backward, a PSW was observed assisting the resident with their meal.

The clinical health record for the resident was reviewed. Documentation identified the resident was dependent on staff for all activities of daily living.

The Clinical Care Coordinator (CCC) and the DOC confirmed that the resident's mobility device should have been properly positioned during meals. The CCC and the DOC indicated it is an expectation that residents are safely positioned prior to and during mealtimes.

Failure of the licensee to ensure residents were safely positioned at meals and snacks posed risk of harm to residents.

Sources: Observations; and interviews with RAI-C, CCC, and the DOC.

WRITTEN NOTIFICATION: Police notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure the police were immediately notified of a suspected incident of resident abuse.

Rationale and Summary

The licensee submitted a CI to the Director regarding the suspected abuse of a resident.

The clinical health records for two residents, CI, and the licensee's investigation were reviewed. Documentation identified the suspected abuse incident that occurred on a specific day. Documentation identified the police were not immediately notified of the suspected abuse.

The DOC indicated that the police should have been immediately notified of the suspected abuse of the resident.

Failure to notify police of a suspected incident of resident abuse delays potential police investigations and posed risk to the resident and others.

Sources: Review of the clinical health record for both residents, licensee's

investigation, Police Report File, CI, licensee's policies regarding zero tolerance of abuse and neglect of residents; and interviews with RNs, Behaviour Support Lead-RPN, DOC and the Administrator.

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

The licensee must:

1. The DOC is to re-train two RNs in person on the licensee's zero tolerance of abuse policy. Document the date the education was provided, the name of the person who provided the education, and the names of the staff who have completed the education. Documentation is to be kept and made immediately available to the inspector upon request.

2. The Director of Regional Operations is to re-train the Administrator in person on the licensee's zero tolerance for abuse policy, specifically, regarding their role and

responsibility surrounding making immediate reports to the Director, investigating alleged, suspected, or witnessed incidents of abuse residents, notification of substitute decision maker or others, and notification of police. Document the date the education was provided, the name of the person who provided the education, and the name of the staff who have completed the education. Documentation is to be kept and made immediately available to the inspector upon request.

3. The Director of Care must conduct weekly audits of reported incidents of resident abuse for a period of 4 weeks, to ensure that the licensee's zero tolerance of resident abuse policy is being complied with. Keep a documented record of all audits completed and any corrective actions taken. Documentation must be made immediately available to the Inspector upon request.

Grounds

The licensee failed to ensure their written policy to promote zero tolerance of abuse of residents was complied with.

Rationale and Summary

A CI was submitted to the Director regarding suspected abuse of a resident.

The licensee's policies, 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting Incidents of Abuse' direct that all employees of OMNI are to follow the zero tolerance of abuse policy. The policies direct that:

- Any person who has reasonable grounds to suspect that a resident has been abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director, Home's Administrator or Manager

On Call, and the Director of Operations for OMNI Quality Living.

- In the event of an allegation or complaint of abuse by a resident the charge nurse in consultation with the manager on call shall assess the risk and severity of the incident.

- Police are to be notified of any alleged, suspected or witnessed abuse of a resident, immediately after the incident was reported.

- A resident's family or substitute decision-maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect immediately after it is reported and subsequently contacted to notify them of the results of any investigation conducted.

The clinical health records for both residents were reviewed. Documentation identified a resident was heard calling out, staff entered the room to discover the resident in bed with injuries. Documentation identified the co-resident, who was identified as the aggressor, had injuries. The resident indicated they were injured by the co-resident.

Both RNs indicated it was 'obvious' there had been an altercation between the two residents, due to the assessment of the bedroom, and that both residents had injuries. RN indicated they had contacted the Administrator, who was the On Call Manager, and reported what was observed, specifically that, both residents were injured, the RN indicated being told by the Administrator that the incident was not a Critical Incident. Both RNs indicated they did not report the suspected abuse to the Director as they were directed otherwise by the Administrator. The RN's indicated they did not report the suspected abuse and/or injuries to the resident's SDMs as they were directed by the Administrator such could wait until the next shift. The

RN's indicated they did not report the incident to the police as they were told by the Administrator that the incident was not a CI. The RN's indicated disbelief that the incident was a CI, but indicated it was their belief they could take no further action as they were given direction by the Administrator. Both RNs indicated awareness of the licensee's policies related to zero tolerance of resident abuse and indicated the policy was not followed.

The Administrator indicated it was their belief they were not given adequate information about what had been discovered when they were called by RN, and hence did not suspect abuse of a resident had occurred.

The DOC confirmed both RNs and the Administrator did not comply with the licensee's zero tolerance of resident abuse policy.
Failure of the licensee to ensure staff comply with their zero-tolerance abuse policy posed gaps in care and services afforded to residents, dereliction of staff and manager duties, and most importantly placed residents at risk of harm.

Sources: Review of the clinical health records for the residents, CI, licensee investigation, licensee's policies 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting Incidents Of Abuse'; and interviews with RNs, DOC and the Administrator.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

The licensee must:

1. The DOC is to review in person, the definitions of verbal, emotional, and physical abuse, and section 28 of the Act with two specific RNs. Keep a documented record of the education provided, including the date, time, and signature of the trainee and the trainer. The document is to be kept and made immediately available to the Inspector upon request.

2. The Director of Regional Operations is to review in person, the definitions of verbal, emotional, and physical abuse, and section 28 of the Act with the Administrator. Keep a documented record of the education provided, including the date, time, and signature of the trainee and the trainer. The document is to be kept and made immediately available to the Inspector upon request.

3. The Director of Regional Operations must develop and implement a policy, plan, or strategy to guide staff if a conflict arises between the staff and the direction from managers related to the reporting of alleged, suspected, or witnessed incidents of resident abuse and neglect, to ensure incidents are reported to the Director. The

policy, plan, or strategy must be documented and communicated to all registered nursing staff, including agency staff and managers. Documentation must be kept and made immediately available to the Inspector upon request.

4. The Director of Regional Operations must conduct daily audits of any reported incidents of resident abuse for a period of 4 weeks, to ensure that the licensee's zero tolerance of abuse policy is being complied with. Corrective action must be immediately taken if deficiencies are identified. Audits must be documented, and include date, time, Critical Incident #, auditors name and signature, and any corrective action taken. Documentation is to be kept and made immediately available to the Inspector upon request.

Ground

The licensee failed to immediately report suspected abuse of a resident to the Director.

Pursuant to O. Reg. 246/22, s. 2 (1), For the purposes of the definition of “abuse” in subsection 2 (1) of the Act,

“Physical abuse” means, subject to subsection (2), the use of physical force by a resident that causes physical injury to another resident.

“Verbal abuse” means, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

“Emotional abuse” means, any threatening or intimidating gestures, actions,

behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Rationale and Summary

A CI was submitted to the Director regarding suspected abuse of a resident, by another resident. The CI was immediately reported to the Director.

The clinical health records for both residents were reviewed. Documentation identified a resident was heard calling out, staff entered the room to discover the resident in bed with injuries. Documentation identified the co-resident had injuries. Documentation indicated the resident indicated they had been injured by the co-resident.

Both RNs indicated it was 'obvious' there had been an altercation between the two residents, due to the assessment of the resident's room and injuries to both residents. RN indicated they had contacted the Administrator, who was the On Call Manager, and reported what was observed, specifically that, both residents were injured, the RN indicated being told by the Administrator that the incident was not a Critical Incident. Both RNs indicated they did not report the suspected abuse to the Director as they were directed otherwise by the Administrator. The RN's indicated awareness of the requirement to immediately report alleged, suspected, or witnessed abuse to the Director.

The Administrator indicated it was their belief they were not given adequate information about what had been discovered when they were called by the RN and hence did not suspect abuse of a resident had occurred.

The Administrator confirmed the suspected abuse of a resident was not immediately reported to the Director.

The DOC indicated that the suspected abuse incident should have been immediately reported to the Director.

Failure of the licensee to immediately notify the Director of incidences of alleged, suspected, or witnessed abuse of a resident posed gaps in care and services and delays potential inspections by the Ministry of Long-Term Care.

Sources: Review of the clinical health record for the residents, CI, licensee's investigation; and interviews with RNs, Behaviour Support Lead-RPN, DOC, and the Administrator.

This order must be complied with by December 6, 2024

COMPLIANCE ORDER CO #003 Notification re incidents

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee must:

1. The DOC will provide in-person training to two specific RNs regarding legislation O. Reg. 246/22, s. 104 related to the notification of the resident's SDM, related to incidents of alleged, suspected, or witnessed abuse of a resident.

2. The Regional Director of Operations will provide in-person training to the Administrator regarding legislation O. Reg. 246/22, s. 104 related to notification of resident's SDM, related to incidents of alleged, suspected, or witnessed abuse of a resident.

3. Documentation of the training for condition #2 and condition #3, including the date the training occurred, staff and or manager's name, and who provided the training must be recorded, kept, and made immediately available to the Inspector upon request.

4. The DOC must re-communicate, to all registered nursing staff and managers, the licensee's zero tolerance of abuse policy, specifically as such relates to notification of the SDM when allegations, suspected or witnessed abuse of a resident occurs. The communication must be documented, kept, and made immediately available to the Inspector upon request.

Grounds

1. The licensee failed to ensure that a resident's SDM was immediately notified of a suspected abuse of a resident that resulted in physical injury, pain, and distress to a resident.

Rationale and Summary

The licensee submitted a CI to the Director regarding the suspected abuse of a resident by a co-resident.

The clinical health record for the first resident was reviewed. Documentation confirmed there was an altercation between the residents. Documentation identified the resident was assessed as having injuries, was complaining of discomfort, and was in distress. Documentation failed to identify the resident's SDM was immediately notified of the incident which resulted in injury, discomfort, and distress.

Both RNs confirmed the resident had injuries, was in discomfort, and in distress following the incident. The RNs indicated they were directed by the Administrator to wait until the next shift, to notify the resident's SDM of the incident and injuries. The DOC indicated the resident's SDM should have been immediately notified of the incident.

Failure of the licensee to immediately notify a resident's SDM of a suspected abuse incident, which resulted in injury, discomfort, and distress of a resident posed gaps in care and services afforded to a resident, specifically related to the licensee's zero tolerance of abuse and neglect program, posed issues related to disclosure and transparency, therapeutic care relationships and delayed support of the resident by their SDM.

Sources: Review of the clinical health record for a resident, licensee's investigation, CI, licensee's policies regarding zero tolerance of abuse and neglect of residents; and interviews with RNs, Behaviour Support Lead-RPN, DOC, and the Administrator.

2. The licensee failed to ensure that a resident's SDM was immediately notified of a suspected abuse of a resident that resulted in physical injury, pain, and distress to a resident.

Rationale and Summary

The licensee submitted a CI to the Director regarding the suspected abuse of a resident by a co-resident.

The clinical health record for the resident was reviewed. Documentation confirmed there was an altercation between the residents. Documentation identified the resident was assessed as having injuries, resulting from the altercation. Documentation failed to identify the resident's SDM was immediately notified of the incident which resulted in injury.

Both RNs confirmed the resident had injuries resulting from the incident. The RNs indicated they were directed by the Administrator to wait until the next shift to notify the resident's SDM of the incident. The DOC indicated the resident's SDM should have been immediately notified of the incident.

Failure of the licensee to immediately notify a resident's SDM of an incident, which resulted in injury posed gaps in care and services afforded to a resident, specifically related to the licensee's zero tolerance of abuse and neglect program, and delayed potential involvement of the SDM in measures to be taken following the incident, and support to the resident as needed.

Sources: Review of the clinical health record for the resident, licensee's investigation, CI, licensee's policies regarding zero tolerance of abuse and neglect of

residents; and interviews with RNs, Behaviour Support Lead-RPN, DOC, and the Administrator.

This order must be complied with by December 6, 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

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.