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

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Original Public Report

Report Issue Date: August 29, 2024

Inspection Number: 2024-1708-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Partners Community Health

Long Term Care Home and City: Wellbrook Place West, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, 12, 15-19, 22-26, 29-31, 2024 and August 1, 2024

The following intake(s) were inspected in this critical incident (CI) inspection:

- Intake: #00108821 CI-3067-000009-24 - Related to resident care and support services
- Intake: #00109674 CI-3067-000018-24 - Related to prevention of abuse and neglect

- Intake: #00112478 CI-3067-000029-24 - Related to prevention of abuse and neglect
- Intake: #00116905 CI-3067-000043-24 - Related to infection prevention and control.

The following intake(s) were inspected in this complaint inspection:

- Intake: #00115733 - Complainant related to concerns with resident care and support services
- Intake: #00117909 - Complainant with concerns regarding Plan of care, medication management system.
- Intake: #00118302 - Complainant with concerns regarding Resident Care and Support Services

The following intake(s) were inspected as follow up compliance orders

- Intake: #00117380 - Related to a follow-up to compliance order (CO) for Ontario/Regulations (O. Reg.)246/22 - s. 96 (2) (a), with a compliance due date of July 5, 2024.
- Intake: #00117381 - Related to a follow-up to compliance order (CO) for Ontario/Regulations (O. Reg.)246/22 - s. 79 (1) 5, with a compliance due date of July 5, 2024.
- Intake: #00117382 - Related to a follow-up to compliance order (CO) for Ontario/Regulations(O. Reg.) 246/22 - s. 12 (1) 3, with a compliance due date of July 5, 2024.
- Intake: #00117383 - Related to a follow-up to compliance order (CO) for Ontario/Regulations (O. Reg.) 246/22 - s. 102 (2) (b), with a compliance due date of July 5, 2024.
- Intake: #00117384 - Related to a follow-up to compliance order (CO) for Ontario/Regulations(O. Reg.)246/22 - s. 74 (2) (e) (i), with a compliance due date of July 5, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 from Inspection #2024-1708-0001 related to O. Reg. 246/22, s. 96 (2) (a) inspected by Waseema Khan (741104)
Order #003 from Inspection #2024-1708-0001 related to O. Reg. 246/22, s. 79 (1) 5. inspected by Patrishya Allis (000762)
Order #001 from Inspection #2024-1708-0001 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Waseema Khan (741104)
Order #005 from Inspection #2024-1708-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Stephany Kulis (000766)
Order #002 from Inspection #2024-1708-0001 related to O. Reg. 246/22, s. 74 (2) (e) (i) inspected by Waseema Khan (741104)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for resident set out the planned care for the resident.

Rationale and Summary
Resident room was observed to have a device present. Staff stated the purpose was to prevent co-residents from wandering into their room. There was no documentation within the resident's plan of care that the resident required use of the device. Staff acknowledged that the device should be documented in the care plan.

The device was removed from resident door and plan of care updated.

Sources: Observations of resident's room, resident's clinical records, and interview with staff.

Date Remedy Implemented: July 30, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that the requirement of keeping the staff locker room door, which leads to non-residential area was locked to restrict access.

Rationale and Summary
During an observation on a day in July 2024 inspector was able to push open the staff locker room door on the fourth floor West C wing without using an access card. Registered Practical Nurse (RPN) and Registered Nurse (RN) acknowledged that staff typically use the access card, which is why the unlocked state went unnoticed. They confirmed that the door should indeed be locked and only accessible with an access card. Registered RN verified that they had noticed the issue and a maintenance request would be submitted.

An interview with RPN confirmed that a maintenance request for the staff locker room door was sent, and it has since been repaired.

Further observation on a later date in July 2024, showed that the staff locker room door on the fourth floor West C wing was locked and only opened with an access

card. The issue of the door being kept unlocked has been addressed by the home, has been mitigated by the home and this non-compliance has been remedied.

Sources: Observations in July 2024, interviews with an RPN and two RNs.

Date Remedy Implemented: July 16, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 failed to ensure that food being served is at a temperature that is safe to the residents.

Rationale and Summary
The Public Health Agency of Canada's Food Safety Guidelines indicate bacteria can grow in the danger zone between 4 ˚C and 60 ˚C (40 ˚F to 140 ˚F).
The home's policy titled "Servery Food Temperature", last revised January 2022, indicated eggs, entrees, vegetables, potato, gravy, coffee, tea served to residents should be kept at a temperature of 60 ˚C (140˚F) - 76 ˚C (168.8˚F).

On day in July 2024, inspector entered the dining room servery, dietary aide plated a hot dog with a side salad to serve to a resident. Inspector took the temperature of the hot dog with the TPI 318˚C thermometer, which read 43.3˚C (110˚F) and was acknowledged by the dietary aide .

The dietary aide returned the hot dog to the steamer to re-heat.

Inspector and dietary aide checked the hot dog, temperature it was 70.5˚C (158.9˚F). The dietary aide returned back to steamer to reach optimal temperature.

Inspector and dietary aide checked the hot dog, temperature was 74.8˚C (166.6˚F). At that time, the hot dog was served to the resident.

The Food Service Supervisor confirmed the temperature should have been at 74˚C (165.2˚F).

Serving food at unsafe food temperatures increased the risk of potential food borne illness from occurring.

Sources: Observations; interviews with staff, "Servery Food Temperature Policy", last revised January 2022, Public Health Agency of Canada's Food Safety Guidelines last revised April 2012.

Date Remedy Implemented: July 12, 2024

WRITTEN NOTIFICATION: Responsive Behaviors

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee has failed to ensure that the behavioural triggers for resident were identified in the their initial care plan.

Specifically, staff did not comply with the home's policy titled "supporting a resident with responsive behaviors", last revised October 24, 2023.

Rationale and Summary
The Behavioral Support Unit (BSU) policy titled "Supporting a resident with responsive behaviors", last revised October, 2023, indicated "the nursing care plan shall identify the resident's behavioral triggers and be reflective of the individualized supportive measures and BSO strategies that are provided to manage these behaviors."

Resident had responsive behaviors, behavioral triggers, and personal expressions upon admission to the home, which was captured in the behavior assessment tool LHIN placement service form dated January 2024, and was triggered in the admission Mood State and Behavioral Symptoms RAP.

The initial care plan did not identify behavioral triggers that may result in responsive behaviors or written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors, and should have been, this was confirmed by the interim Associate Director of Care (ADOC) , the Behavior Support Specialist (BSS) , and the Registered Nurse (RN) .

RN confirmed the care plan was the first sought out resource utilized by front line staff to identify resident behaviors, triggers, and interventions to respond to the responsive behaviors.

Review of resident's progress notes outlined resident had four interactions with multiple residents that resulted in physical altercations and triggering escalating behaviors of co-residents.

Failure to identify responsive behaviors, behavioral triggers, and supportive measures/strategies to manage behaviors in resident care plan increased the risk of uncontrolled responsive behaviors as staff may have had reduced awareness of strategies to mitigate such behaviors.

Sources: The home's policy, titled "Supporting a resident with responsive behaviors", last revised: October, 2023 Reference, interviews with staff, resident's clinical records.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
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:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that the resident's lifestyle and choices were respected.

Rationale and Summary
On admission, resident's preferences for a specific activity of daily living (ADL) was documented as prefers ADL in the morning. During a four month period, the resident

received the ADL in the evenings documented frequently in the late evening. Staff stated they were aware of the resident's preference and the change to the resident's ADLs times was not respectful of that.

By not following resident's preferences, their lifestyle and choices were not respected.

Sources: Resident's clinical records, and interviews with staff and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident.

The licensee failed to ensure that resident had a written plan that set out the planned care for the resident, specific to promoting and managing bowel and bladder continence.

Rationale and Summary
The home's policy titled "A bowel and bladder continence assessment and care planning", last revised October, 2023, indicated staff are to ensure all residents, where possible, are toileted for example: toilet incontinent residents.

Resident was able to communicate their needs to be toileted and was continent during the day and incontinent during the night, this was confirmed by Personal Support Workers (PSW).

The RAI coordinator and the Interim Director of Care (IDOC) confirmed a toileting routine was indicated for resident Specifically, a check and change toileting schedule should have been implemented in the resident's support actions tab and care plan that identified specific times in which the resident was to be checked and changed or toileted. The IDOC confirmed this was not present in the resident's care plan or support actions tab.

PSW further reported agency PSWs do not consistently toilet the resident because they were unaware of their toileting routine.

Failure to establish a toileting routine for resident increased the risk of a missed toileting opportunity, which may have minimized the resident's independence, comfort, and dignity.

Sources: Interviews with staff, review of resident's care plan, the home's policy titled "A bowel and bladder continence assessment and care planning", last revised October 2023, documentation survey report and support actions tab review.

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that there was a written plan of care for resident that set out clear directions to staff and others who provided direct care to the resident, specific to the continence care and bowel management program.

Rationale and Summary
The care plan review for a resident in July 2024 presents conflicting information regarding urinary incontinence: it states the resident is both totally incontinent, requiring assistance, and continent with no care needs. Additionally, the bowel incontinence review indicated total incontinence requiring assistance, while an assessment from June 2024, reports complete bowel control.

The Resident Assessment Instrument (RAI) Coordinator acknowledged the care plan and assessment documentation were not consistent, did not complement each other, and the care plan was unclear.

Failure to provide clear direction to staff regarding continence care and bowel management for resident increased the risk of a missed toileting opportunity, which may have minimized the resident's independence, comfort, and dignity.

Sources: Interviews with staff, Resident's care plan and Bladder and Bowel Continence Assessment.

WRITTEN NOTIFICATION: Based on assessment of resident

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary
The licensee did not ensure that the care provided to resident, as outlined in the care plan, was based on that resident's needs and preferences.

Resident's plan of care did not specify residents preference of activities based on Leisure and Wellbeing - Assessment.

Activation Aide acknowledged the plan of care needed to outline the approaches and frequency of activities, which should occur one to two times per week. The preferred activities of resident must be recorded in their plan of care . The Activation Aide verified that the current plan of care did not clearly specify, particular activities that resident enjoys.

Failing to specify resident's preferred activities in their plan of care may lead to a lack of participation in activities that are crucial for their psychosocial well-being.

Sources: Resident's Plan of care, assessment, and interview with Activation aide.

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A) Resident's SDM received notification of a test result they were not aware was taken. The Assistant Director of Care (ADOC) stated the SDM was not given a full explanation of what the work-up entailed. Therefore, they did not know the test was performed and did not participate in the decision-making process.

Failing to provide the SDM the opportunity to participate in the resident's plan of care put the resident at risk of not receiving care that reflect their needs.

Sources: Resident's clinical records, and interview with ADOC. [000766]

Rationale and Summary
B) A staff stated they completed resident's admission and did not go over the medical directives. Another staff who completed the first check to process the order, did not go over the medical directives.

Failing to go over the medical directives on admission put the resident at risk for receiving orders without knowledge of the intended use.

Sources: Resident's clinical records, and interviews with staff and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #010 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.

The licensee has failed to ensure that the care set out in resident's plan of care is provided to the resident as specified in the plan, specific to continence care.

Rationale and Summary:
Review of resident's care plan indicated they required two team members for physical assistance to clean and change their incontinence product.

One Personal Support Worker (PSW) has noted that the resident was able to change independently, while another has indicated that one-person assistance is needed.

The home has failed to comply with resident's plan of care to provide two-person assistance to clean and change the resident's incontinence product.

Sources: Interviews with staff and resident's clinical records.

WRITTEN NOTIFICATION: Plan of care

NC #011 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 the provision of care for resident was documented.

Rationale and Summary
Resident's documentation was reviewed on a day in February 2024, when a specific incident occurred. All documentation was missing and not completed for that date.

Failure to ensure that the provision of care for resident was documented had risk for incorrect/incomplete documentation.

Sources: Resident's clinical record, interview with former DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #012 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 failed to ensure that resident was reassessed and the plan of care was reviewed and revised when care set out in the plan was no longer necessary.

Rationale and Summary
Review of resident's care plan indicated the resident required one team member for total physical assistance to move around the unit using the wheelchair to reach their destination (i.e. room and dining room).

On a day in July 2024, resident was observed in their wheelchair self-propelling out of the dining room.

The interviews with two Personal Support Workers and the Registered Practical Nurse revealed that the resident was capable of independent movement, contradicting the care plan's suggestions. This misalignment suggests that the care plan has not been updated to reflect the resident's current mobility status,

The lack of revision and update of the care plan to meet the resident's mobility needs may contribute to unsuitable care provided to the resident.

Sources: Interviews with staff, care plan review, observations.

WRITTEN NOTIFICATION: Consent

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7
Consent
s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

The licensee has failed to ensure that care or services were provided to resident with resident or Substitute Decision Maker (SDM) consent.

Rationale and Summary
On an identified date, a medication adjustment order for a resident was issued before consulting with the resident's SDM. After the order was written, it was documented that the SDM declined the adjustments suggested. The home used a digi pen for the order which sent the order to the pharmacy to be processed. DOC stated there was a delay in confirming the new order which resulted in the prior order to be discontinued and the new order to remain pending. As a result, resident did not receive their medications four days.

Failing to obtain consent prior to initiating orders resulted in the resident's medication regime to be disrupted.

Sources: Resident's clinical records, and interviews with MD, staff, and DOC.

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that upon receipt of a written compliant it was immediately forwarded to the Director concerning the care of a resident in the manner set out in the regulations.

Rationale and Summary
On a day in April 2024, resident's SDM submitted a written compliant via email to the management team. No CIS was submitted to the Director.

Sources: Compliant email, CIS reports, and interviews with the ED.

WRITTEN NOTIFICATION: Falls prevention and management

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has not implemented strategies to reduce or mitigate falls, such as documenting a resident's tendency for self-transferring to the toilet in their care plan and along with the monitoring of another resident.

Rationale and Summary:
A) The Falls Risk Assessment completed in February 2024 and the care plan for resident indicated they were at high risk for falls.

Four personal support workers confirmed that a resident transferred themselves to the toilet. However, there were no instructions in the resident's care plan to alert staff about the resident's propensity for self-transferring to the toilet.

The Director of Care acknowledged that unsupervised self-transfer to the toilet exposed the resident to fall risks, and the care plan failed to note this tendency, which it should have included.

Failing to document the resident's tendency to self-transfer to toilet posed a risk of potential injury to occur as it may have contributed to lack of implemented care measures.

Sources: Interviews with staff, Resident's Care Plan and Falls Risk Assessment.

Rationale and Summary
B) On a day in March 2024, resident was demonstrating responsive behaviors during the early morning, a code white was called. No DOS monitoring was completed to capture the resident's behaviors throughout the day.

Personal Support Worker (PSW) reported resident had increased tendencies to

attempt to walk independently when agitated.

One late afternoon, Resident raised up from the wheelchair and walked to the exit door. No staff attended when the chair alarm signaled.
The resident fell by the exit door and was sent to hospital immediately due to complaints of pain.

Lack of implementation of the fall strategies may have contributed to the fall and hospital admission

Sources: Interviews with staff, resident's clinical records, staff schedule.

WRITTEN NOTIFICATION: Falls prevention and management

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The home has failed to ensure that when resident fell, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that a post fall assessment is completed within 24 hours of a fall.

Specifically, staff did not comply with the home's policy "Falls Assessment Procedure", last revised October 2023.

Rationale and Summary
On a day in March 2024, resident endured an unwitnessed fall and was sent to hospital.

The home's policy titled "Falls Assessment Procedure", last revised October 2023, indicated "the post fall assessment shall be completed within 24 hours of the fall and provided to the Director of Care for review on the electronic record. The completed post fall assessment shall be maintained in the resident's electronic clinical record."

The fall that occurred on this date in March 2024 was not followed by a post-fall assessment. The interim Director of Care has acknowledged this oversight. Failure to complete a post-fall assessment put the resident at risk of not having a comprehensive assessment completed to identify the contributing factors that led to the fall.

Sources: The home's policy titled "the falls assessment procedure", last revised October, 2024, interview with the Interim Director of Care , resident's clinical records.

WRITTEN NOTIFICATION: Pain management

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the

following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that the home's pain management program provided for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the home's pain management program which provided for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids was complied with.

Specifically, staff did not comply with the policy titled "Pain Assessment Policy", October 2023, which required pharmacological and non-pharmacological interventions to be considered when the resident was experiencing pain.

Rationale and Summary
A resident experienced a fall, and a subsequent pain assessment recorded a new moderate pain score post-fall. No PRN (as needed) medication or non-pharmacological interventions were used.

Failing to follow the home's pain management program put the resident at risk of not receiving pain relieving interventions.

Sources: Resident 's clinical records, the home's Pain Assessment Policy, and interviews with staff and DOC.

WRITTEN NOTIFICATION: Pain management

NC #018 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 has failed to ensure that the resident is assessed by using a pain assessment instrument specifically designed for this purpose.

Rationale and Summary
In accordance with O. Reg 246/22, s.11 (1) (b), The policy directed pain assessment to be completed in the event of an incident.

In December 2023, a resident experienced a fall resulting in bruising and a hematoma. They reported hand pain and requested an analgesic for pain relief.

Registered Nurse confirmed that the protocol mandates a pain assessment once pain is acknowledged. Director of Care indicated that a pain assessment was required whenever there's a change in a resident's condition, a report of pain, immediately following a fall, or for further evaluations. The DOC emphasized a comprehensive pain assessment is crucial in these situations.

Specifically, a pain assessment was not conducted for two days following a resident's fall.

Sources: Resident's clinical records, Pain Management Program, Interviews with

DOC and RN.

WRITTEN NOTIFICATION: Responsive Behaviors

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
4. Protocols for the referral of residents to specialized resources where required.

The licensee failed to ensure that protocols for the referral of residents with responsive behaviors to specialized resources were implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that a referral to the Behaviour Support Ontario (BSO) team was initiated for a resident with a history or risk of responsive behaviors and personal expressions.

Specifically, staff did not comply with the home's policy "Supporting a resident with responsive behaviors", last revised October 2023.

Rationale and Summary
The Behavioral Support Unit (BSU) policy titled "Supporting a resident with responsive behaviours", last revised October 2023, indicated "a comprehensive behavioural assessment shall be completed for each resident at the time of admission. If it is determined that there is a history or risk of responsive behaviours/personal expressions, a referral to the BSO team will be initiated."

The Interim Associate Director of Care reported referrals to BSO have not been made for any residents that were in the BSU, including resident, who had a history and risk of responsive behaviors/personal expressions upon admission to the home.

Registered Nurse (RN) reported they were uncertain about the BSO referral process, and confirmed the BSO lead was actively involved in resident care within the BSU.

The procedural process outlined in the home's BSU policy to send a BSO referral for residents that demonstrate responsive behaviors or personal expressions was not complied with by the licensee.

Sources: The home's policy, titled "Supporting a resident with responsive behaviors", last revised: October 2023, interviews with staff, resident's clinical records.

WRITTEN NOTIFICATION: Therapy services

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 65 (a)
Therapy services
s. 65. Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 13 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

The licensee did not ensure that resident received the on-site physiotherapy as determined by their assessed care needs.

Rationale and Summary
Resident was assessed by a physiotherapist in July, 2024, and it was recommended they receive therapy three times a week.

The monthly attendance review for the therapy sessions in July 2024 indicated that the resident did not receive therapy on four occasions. It was confirmed by the Physiotherapist Assistant that despite being scheduled for three therapy sessions per week, the resident did not receive any therapy sessions during one week of July 2024, contrary to the physiotherapist's recommendation.

The impact on residents was minimal; however, there is a potential risk if the assessed needs of residents are not met.

Sources: Resident's Clinical records, Physiotherapist Support Personnel Job Description, Resident attendance worksheet July 2024 and Interviews with Resident, Physiotherapist and Physiotherapist Assistant.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee failed to ensure the dietary service program included the identification of any risks related to dietary services.

In accordance with O. Reg 246/22 s. 11 (1) (b), staff did not comply with the policy titled "Servery Food Temperature", last revised January 2022, which indicated the dietary aide was required to perform a temperature check to ensure items were holding their temperatures at mid-point dining service. The temperature and time were to be recorded on the servery temperature audit form.

Rationale and Summary
Review of the servery temperature forms for a home area in July, 2024 showed a single temperature check was recorded for each meal.

The forms did not capture a second temperature check, mid-way during dining service as there was no space provided in the server temperature form to document this value. This was acknowledged by the Director of Dietary Services.

The inspector entered the dining room servery around lunchtime, where a dietary aide was plating a hot dog with a side salad for a resident. At that moment, the inspector used a thermometer to check the hot dog's temperature, which registered a reading acknowledged by the dietary aide.
Failure to perform and record a temperature check mid-way during dining service increased the risk of unsafe and unpalatable food be served to residents.

Sources: Interview with staff, observations, Servery temperature forms located in the servery area, "Servery Food Temperature Policy", last revised January 2022.

WRITTEN NOTIFICATION: Nutritional care and hydration

programs

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter.

The licensee has failed to ensure that they implemented their weight monitoring system to weigh resident monthly.

Rationale and Summary
Resident was admitted to the home in December 2023. Their admission weight was measured and documented.

In January and February 2024, there was no documented weight for the resident. Through January and February, the resident was often refusing to eat or drink.

Failure to ensure that resident's weight was measured and documented put the resident at risk for potential unrecognized change in weight.

Sources: Resident's clinical record, interview with former DOC

WRITTEN NOTIFICATION: Individualized medical directives and

orders

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 87
Individualized medical directives and orders
s. 87. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs.

The licensee has failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs.

Rationale and Summary
The home's MediSystem policy, dated December 2023, included that medication orders must contain the specific dosing times of a medication.

A resident was ordered a medication which they were taking prior to admission. On admission, the medication was ordered without a specified dosing time. Registered Pharmacist (RPh) stated that when the dosing time was not provided on admission, a default time was used. The default time used for the order was different from the time the resident was taking the medication prior to admission. MD stated they did not include the specific time; however, medication orders should be individualized to the specific resident including the administration times.

Failing to provide a specific administration time for a medication put the resident at risk of not having orders individualized to meet their needs.

Sources: Resident's clinical records,, the home's MediSystem policy, and interviews

with RPh and MD.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that the resident's identified on the home's line list had symptoms of infection documented every shift as required.

Rationale and Summary
During an outbreak declared in May 2024, four residents were listed as symptomatic with respiratory symptoms. There were multiple shifts where the documentation in the progress notes related to symptom monitoring were missed.

By not documenting the residents' symptoms on an ongoing basis, there was risk that the residents' symptoms were not managed as required.

Sources: Resident's progress notes; Outbreak Line List, the home's surveillance and reporting policy and interview with the IPAC Lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #025 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

- Re-educate PSWs on the specified floor regarding any related policies for following direction provided by Registered Staff;
- Educate all Associate Directors of Care (ADOCs) on the home's internal investigation procedure following incidents of alleged abuse;
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee has failed to ensure that a resident was protected from abuse by staff and has failed to protect resident

failed to protect a resident from abuse by another resident

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines “physical abuse" as (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Section 2 of O. Reg., 246/22 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A) During the month of March, a direct care staff cut a resident's toenails after being instructed by RPN not to cut them. The RPN instead wanted to make a referral to a chiropodist. Two toenails were cut too close to the skin and resulted in bleeding.

The resident did not report pain and there were no further concerns regarding pain or infection.

Failure to ensure that resident was protected from abuse led to a physical injury.

Sources: Resident's progress notes, interview with RPN

Rationale and Summary

B) There were two incidents, one in February 2024 and another in March 2024, where resident was found to be in a sexually inappropriate position

Staff intervened and separated the residents, however one of the residents exhibited responsive behaviors. Following the incident, the affected/abused resident was relocated to another home area for the night and placed under one to one monitoring.

There were no other safeguards in place, aside from hourly location checks. The internal investigation by the home failed to provide an accurate description of the events, and the report to the Ministry of Long-Term Care (MLTC) contained inaccuracies.

Police were called in for assistance after a second incident with accused resident exhibited unmanageable responsive behaviors towards staff. The resident was sent to hospital and was transferred to a different home area upon their return to the home. However , there was no internal investigation.

A resident's safety and wellbeing was a risk when the license failed to assess and implement interventions specific to a another residents responsive behaviours.

Sources: Both resident's progress notes and plans of care, CI 3067-000018-24, interviews with PSWs, RPN , RN, and former DOC .

This order must be complied with by

September 12, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #026 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 shall:

- Educate all Personal Support Workers and Registered Staff to outline their roles and responsibilities when there is suspected or alleged abuse or neglect, including but not limited to their duty to report certain matters to the Director;
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee has failed to ensure that the 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 was reported to the Director immediately.

Rationale and Summary

A) A resident had a history of responsive behaviours, which included being physically and verbally responsive to staff and co-residents.

In March 2024, one resident physically assaulted another by grabbing the back of their shirt and pulling them down, causing the victim's head to strike the floor.

A Critical Incident Report (CI) was submitted by the home in March 2024. The Afterhours Infoline (AI) was not contacted by the home.

Registered Nurse (RN) who worked during the time of the incident, reported the incident to charge nurse. The charge nurse assumed it was the responsibility of the Registered Nurse to report to the Director and the Registered Nurse assumed it was the responsibility of the charge nurse. The roles related to reporting to the Director were unclear.

By not reporting the allegation of resident-to-resident physical abuse immediately to the Director, put the resident at further risk of harm or abuse.

Sources: Review of CI#: 3067-000029-24, staff interviews, resident clinical records.

Rationale and Summary

B) In March 2024, a Registered Practical Nurse (RPN) advised a direct care staff member against trimming a resident's toenails, indicating that a referral to a chiropodist would be made. Despite this, the staff member proceeded with the trimming, causing injury to the resident. The incident went unreported to the Director through both the CI reporting system and the Ministry's after-hours Action Line.

RPN stated they were unaware of the Ministry's after-hours Action Line and had informed the next shift.

Failure to ensure that an incident of abuse was immediately reported to the Director, put resident at further risk of harm or abuse.

Sources: Resident's progress notes, CI reporting system, interview with RPN.

Rationale and Summary

C) The home submitted a CI report to the Ministry of Long-Term Care on February 21, 2024, for an incident of alleged/witnessed abuse that occurred on February 18,

2024. The Ministry's after-hours Action Line was called February 19, 2024, at 0802 hours, more than 12 hours after the incident occurred.

The home was unable to explain why the incident was not reported immediately.

Failure to ensure that an incident of abuse was immediately reported to the Director, put residents at risk of harm or abuse.

Sources: CI: 3067-000018-24, Infoline: IL-0123276-AH, interview with former DOC.

Rationale and Summary

D) There was an incident of alleged/witnessed sexual abuse, between two residents. The Ministry's after-hours Action Line was not called to report this incident. The home submitted a CI report to the Ministry of Long-Term Care for a separate incident involving the same two residents that occurred on another date and added the second incident to the CI report. The CI report was submitted two days after second incident occurred.

The home stated they considered the second incident as a continuation of the first and that was why it was added to the initial CI.

Failure to ensure that an incident of abuse was immediately reported to the Director, put residents at risk of harm or abuse.

Sources: CI: 3067-000018-24, interview with former DOC.

This order must be complied with by

September 25, 2024

COMPLIANCE ORDER CO #003 Training

NC #027 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (2) 3.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

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

The licensee shall:

- Educate all Personal Support Workers and Registered Staff, including Associate Directors of Care, regarding the home's policies on zero tolerance for abuse and prevention of abuse and neglect.
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee did not ensure that three staff members were trained on the home's policy, which promotes zero tolerance of abuse and neglect of residents.

Rationale and Summary

During the inspection, it was noted that staff had not reported incidents of abuse immediately. Education records were reviewed and three staff were noted to have not completed training on the home's prevention of abuse and neglect policies.

Failure to ensure that staff received training on the home's zero tolerance of abuse and neglect policies put residents at risk for staff not recognizing incidents of abuse.

Sources: Education records, interview with Executive Director (ED).

This order must be complied with by

November 8, 2024

COMPLIANCE ORDER CO #004 Training

NC #028 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

4. The duty under section 28 to make mandatory reports.

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

The licensee shall:

- Educate all Personal Support Workers and Registered Staff, including Associate Directors of Care, regarding the duty to make mandatory reports for incidents of abuse or neglect.
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee did not ensure that the three staff members were trained on the obligation to make mandatory reports as required by section 28.

Rationale and Summary

During the inspection, it was noted that staff had not reported incidents of abuse immediately or at all. Education records were reviewed and three staff were noted to have not completed training on the duty to make mandatory reports.

Failure to ensure that staff received this training put residents at risk for further harm or abuse.

Sources: Education records, interview with ED.

This order must be complied with by

November 8, 2024

COMPLIANCE ORDER CO #005 Responsive behaviours

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

- Create (or update) and implement the home's process regarding review of completion of Dementia Observation System (DOS) to ensure staff have initiated the monitoring and completed the monitoring within the specified timeframe;
- Educate all Personal Support Workers, Registered Staff on their responsibility to complete and document DOS monitoring;
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee did not ensure the completion and documentation of behavior monitoring for the two residents using the home's Dementia Observation System (DOS).

Rationale and Summary

A) The Associate Director of Care (ADOC) requested that the BSO Behavioral Support Ontario-DOS Data Collection Sheet documentation be initiated for a resident in March 2024, following an incident of responsive behaviors that resulted in a code white. However, this documentation was neither initiated nor completed, a fact which the ADOC acknowledged.

Not initiating and completing the BSO-DOS Data Collection Sheet for behavioral monitoring could risk failing to identify, assess, or intervene appropriately in residents' responsive behaviors when they were not being monitored.

Sources: Resident's BSO-DOS forms, interview with the ADOC, Progress notes, resident's clinical records.

Rationale and Summary

B) DOS for a resident was initiated following an incident in February 2024. The resident's DOS Collection Sheet could not be found in their records, and the home was unable to locate it.

Failure to ensure the DOS Collection Sheet was completed posed a risk that resident 's responsive behaviours that may have required follow-up, would not be identified.

Sources: Resident 's clinical records, interview with Executive Director (ED).

This order must be complied with by

September 25, 2024

COMPLIANCE ORDER CO #006 Medication management system

NC #030 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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

The licensee shall:

1. Educate all registered nursing staff on the home's medication management policy specifically the following topics: medication reconciliation on admission, process and procedure for the use of digi pen, prescriber's digi order forms content, process and procedure, and medication administration; and
2. Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee failed to comply with the written policies and protocols developed for the medication management system for two residents .

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols are developed for the Medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home were complied with.

Specifically, staff did not comply with the home's MediSystem policy, dated December 2023, which was included in the home's Medication management program.

Rationale and Summary

A) During a month of March, a medication adjustment order for a resident was submitted to the pharmacy using a Digi pen. The previous order was cancelled, and the new order stayed pending until confirmation was received at a subsequent date. During this time, the initial nursing check was not completed, resulting in the resident not receiving their medication for three days.

Failing to complete the first nursing check resulted in the resident's medication regime to be disrupted.

Sources: Resident's clinical records, Medisystem policy, and interviews with DOC and staff.

Rationale and Summary

B) An order on resident's prescriber's Digi order forms identified use of regular pen after the original Digi order was processed in the system with no identification of the

form being faxed afterwards. DOC stated due to regular pen used, a referral ordered was delayed and required to be reordered.

Failure to use the Digi pen put the resident at risk in delayed orders and referrals.

Sources: Resident's clinical records, Policies and Procedures: Manual for MediSystem Serviced Homes, and interview with staff and DOC .

Rationale and Summary

C) Resident's prescriber's Digi order forms demonstrated multiple order entries with missing information that included: date and time order was written, specific dosing times and specified start date, and signature and license number of the prescriber.

Failure to include all the required order components put the resident at risk of not receiving medications as prescribed.

Sources: Resident's clinical records, Policies and Procedures: Manual for MediSystem Serviced Homes, and interview with RPh, MD and DOC.

Rationale and Summary

D) A staff completed resident's medication reconciliation form on admission. The form indicated one source was used to complete the resident's medication history. Multiple medication orders were not complete.

Failure to use a minimum of two sources put the resident at risk of not receiving on the correct medications.

Sources: Resident 's clinical records, Policies and Procedures: Manual for MediSystem Serviced Homes, the home's Medication Reconciliation policy and interview with RPh and staff.

Rationale and Summary

E) In July 2024, a pill was observed on the floor of a resident's room.

Associate Director of Care (ADOC) acknowledged the resident might have spat out the pill and staff should have ensured that the resident swallowed the pill.

The home's manual for MediSystem Serviced Homes, dated December 2023, under section 19 for Medication Administration, stated, "Administer medications to the resident ensuring that all oral medications have been swallowed".

Failure to ensure that the home's policy was followed for medication administration put resident at risk of harm.

Sources: Observations, interview with ADOC, the home's MediSystem policy.

This order must be complied with by

September 25, 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.