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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 26, 2024	
Inspection Number: 2024-1375-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Chippawa Creek Care Centre Ltd.	
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls	
Lead Inspector Erika Reaman (000764)	**Inspector Digital Signature**
Additional Inspector(s) Carla Meyer (740860)	

INSPECTION SUMMARY

Inspection occurred on site on the following date(s): January 10-12, 2024; January 15-16, 2024; January 18-19, 2024; January 22-26, 2023.

Inspection occurred off site on the following date(s): January 24, 2024.

The following intake(s) were inspected:

- Intake: #00104030 - Complaint with concerns regarding admissions, absences and discharge.
- Intake: #00104054 - Complaint with concerns regarding admissions, absences and discharge.
- Intake: #00102774 - Complaint with concerns regarding resident care and

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medication management.
· Intake: #00105548 Critical Incident (CI) # 2890-000001-24- Infection Prevention and Management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Residents' Rights and Choices
Admission, Absences and Discharge

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: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes revised September, 2023 was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

An observation completed by inspector while the home was in a whole home outbreak, identified that Alcohol Based Hand Rub (ABHR) was expired in May 2022 on a cart in front of a resident on isolation's room. A second observation of the homes ABHR completed identified multiple expired and/or empty in various areas of the home.

The administrator was made aware of this by inspector, and they indicated these would be replaced.

Failing to provide a minimum 70% ABHR may have increased the risk of transmission of infections.

A final observation of the home's ABHR was completed, and inspector went around home to observe ABHR throughout the home. It was observed that expiry dates were added to the front of the ABHR's, and there were no expired and/or empty ABHR observed.

Sources: Observations; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022 and revised September 2023

Date Remedy Implemented: January 25, 2024
[000764]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

The licensee has failed to 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
A resident's clinical records showed multiple progress notes where the resident's Substitute Decision Maker (SDM) requested the resident to take their medication in a certain way. The resident's written plan of care showed that this intervention was not included.

The Director of Care (DOC) acknowledged that this was not added to the resident's plan of care and indicated that this may have been due to the resident receiving medication that could not be given with a specific food or that a specific medication the resident received could not be crushed. However, the home's pharmacy indicated based on the Drug Identification Number (DIN) for this medication, that it could be crushed.

Failure to ensure that a request from the SDM was incorporated into the resident's care plan, had potential for not having their/SDM's preferred method used.

Sources: Resident's clinical records, review of PACMED report, interview with DOC.
[000764]

WRITTEN NOTIFICATION: Plan of Care

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

The Licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident.

Rationale and Summary
The home's physician wrote an order indicating that the resident's SDM could provide certain care to resident. Review of the resident's clinical records listed special instructions indicating that SDM could provide this care. A staff indicated that they would not give items when requested by the SDM. When asked if they were aware of a physician order that the SDM could provide this care to the resident against medical advice, they indicated that they were not aware.

Interview with DOC stated that staff would be made aware of physician orders in their daily reports.

Not providing care to the resident as outlined in the plan of care did not comply with the plan.

Sources: Resident's clinical records, interview with staff. **[000764]**

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that an incident of resident-to-resident abuse was reported immediately to the Director.

Rationale and Summary
A review of a resident's clinical records stated there was a physical altercation with a co-resident on a specified date in November 2023 resulting in an injury to the co-resident.
A search on the Ministry of Long-Term Care Home's (MLTCH) portal was conducted and no reports were found related to this incident, nor was the after-hours information line called. The Administrator acknowledged that no CI report was submitted.

By failing to submit a CI immediately to the Director, the home failed to follow the

legislative requirements.

Sources: Resident's clinical records, the home's policy "Critical Incident (CI) Reporting (ON)", last reviewed January 2022, and "Zero Tolerance of Resident Abuse and Neglect Program", last reviewed January 2022, MLTCH portal; and interviews with staff, the DOC, Administrator, Resident Assessment Instrument (RAI)-Back up, and the Admissions and Social Services Coordinator (ASSC). **[740860]**

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee failed to ensure that the residents on a specific dining area were provided with hand hygiene prior to receiving their meals.

Rationale and Summary
As per section 10.2 (c) of the "Infection Prevention and Control (IPAC) Standard", the licensee shall ensure that the hand hygiene program for residents has a resident-centered approach with options for residents, while ensuring the hand hygiene program is being adhered to. The hand hygiene program must include: assistance to resident to perform hand hygiene before meals and snacks.

On a specific date while the home was in a whole home outbreak staff were observed bringing residents into a specific dining area. Staff were not observed to be assisting any residents with hand hygiene prior to receiving their meals. Interview with staff indicated that staff are to provide assistance to residents prior to meal service.

Failing to provide handing hygiene to residents posed a risk of spreading infection.

Sources: Staff observations; interview with staff; IPAC Standard for Long-Term Care Homes April 2022 and revised September 2023. **[000764]**

WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

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

and Promotion Act.

Rationale and Summary
A Critical Incident (CI) report was submitted on a date, in relation to a respiratory outbreak. The IPAC lead confirmed the date that the outbreak was declared by public health. However, the CI was submitted a few days after it was confirmed by public health.

When the director was not immediately informed there was a risk to residents that elements of the IPAC program were not being implemented properly.

Sources: IPAC Lead; record review of CI. **[000764]**

WRITTEN NOTIFICATION: When licensee may discharge

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (2)
When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure that prior to discharging a resident, that they were informed by anyone permitted to do so pursuant to s. 157 (2) of the Ontario Regulations (O. Reg.) 246/22 that the resident's requirements for care had changed

and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

Rationale and Summary
A resident resided at the home from an identified date. During that period, the fundamental principle of the Fixing Long-Term Care Act, 2021 was applied. This meant that the long-term care home was primarily the home of the resident and was to be operated so that it was a place where they may live with dignity and in security, safety, and comfort, and have their physical, psychological, social, spiritual, and cultural needs adequately met.

On the morning of a specified date in December 2023, the DOC and Resident Assessment Instrument (RAI) Backup Coordinator, had a conversation with the resident which led to the resident exhibiting behaviors. The resident was assessed by the home's physician and the was transferred to the hospital for a follow-up.

The emergency contact and next of kin for the resident was contacted and was informed of the events that occurred leading up to the transfer of resident to the hospital as per progress notes reviewed.

During an interview with the physician, they indicated that they were not aware that the resident was officially discharged from the long-term care home. They also acknowledged that they did not inform the licensee of the resident's discharge.

The licensee and the Chief Nursing Office (CNO) for the home acknowledged that they were not aware of the resident's discharge.

When the home failed to follow regulatory requirements related to when the licensee may discharge a resident, relevant information by the attending physician

who assessed the resident at the hospital was not conveyed to the licensee which may have impacted the decision to discharge the resident.

Sources: Resident clinical records, review of e-mail correspondence between the home's leadership team, and interview with the DOC, Administrator, Physician, and the Licensee and the Chief Nursing Officer of the Licensee. **[740860]**

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (1) (b)
Requirements on licensee before discharging a resident
s. 161 (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge.

The licensee failed to ensure that they provided notice of discharge to a resident.

Rationale and Summary
A resident's clinical records showed that they were their own Power of Attorney for care.

On a specified date, the resident was transferred to the hospital. On the same day, the home officially discharged the resident from the home.

As per the resident, they were not aware that they were being discharged from the home. They also stated that they have contacted the home but have not had their phone calls returned. Then home acknowledged that they were aware that the resident had called the home several times.

The home's policy titled "Discharge," last reviewed January 2022, stated that the home must provide as much advance notice as possible before discharging the resident, and prior to discharge, the home must notify the resident, the resident's SDM and any other individual as directed by the resident. In cases where advance notice cannot be given, then notice must be provided as soon as possible following the discharge.

The DOC stated that they only informed the resident's family verbally via telephone call that the resident will not be returning to the home, and the Administrator acknowledged that they did not provide formal communication to the resident of their discharge.

By not informing the resident of their discharge from the home, their rights were impeded and may have negatively impacted their ability and chance of finding appropriate supports, as well as the ability to express their wishes regarding their discharge.

Sources: Resident's clinical records, a review of e-mail correspondences between the home's leadership team, the home's policy, titled "Discharge," last reviewed January 2022, and interview with resident, resident's family, DOC, and Administrator. **[740860]**

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee failed to collaborate with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required by a resident before discharging the resident.

Rationale and Summary
On a specified date, a resident was discharged from the home following a transfer to the hospital. The home's DOC documented that the resident's family was contacted and informed of the resident's transfer.

The resident's clinical records showed no other communication with HCCSS prior to their discharge. The Administrator stated that they had communicated with HCCSS, formerly known as the LHIN, but did not have this in writing.

The home's policy, titled "Discharge," last reviewed January 2022, also stated that the Director of Care/designate will coordinate each discharge with the placement coordinator/provincial regulatory authority to ensure that alternative arrangements are made for the accommodation, care, and secure environment for the resident.

When the home did not collaborate with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required by the resident, the resident's rights were not considered which had a negative impact on the resident when they were discharged without notice and without any of the personal belongings.

Sources: Resident's clinical records, the home's policy, titled "Discharge," last reviewed January 2022, review of e-mail correspondence between the home's leadership team and HCCSS, and interview with the Admissions and Social Services Coordinator (ASSC), the Administrator, resident, Physician, and HCCSS Patient Care Manager. **[740860]**

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

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

1. Review the home's policy titled Suicide Assessment, Prevention and Support. This review shall be completed by all members of the Nursing leadership team; and

2. Provide education to all registered staff on the above policy specifically focusing on the frequency of when a risk assessment must be completed for residents; and
3. Maintain a record of the nursing leadership team's review, and the re-education provided to the registered staff on the home's policy, including the date and time the review and re-education took place, the name of the person who conducted and provided the review and re-education, and the names, title, and signature of the person completing the review and receiving the education; and
4. Ensure that the record is readily available for the MLTC inspector.

Grounds
The licensee failed to ensure that an assessment was completed for a resident when they expressed negative thoughts as per the home's policy.
According to O.Reg.246/22, s. 11 (1) (b), where an Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that it is complied with.

Rationale and Summary
The resident’s clinical records showed that they had a history of having and expressing negative thoughts.

There were no risk assessments completed for the resident during these times.

A staff member and the DOC acknowledged that a risk assessment should have been completed when a resident expressed negative thoughts.

By not completing the appropriate assessment for the resident when they expressed negative and thoughts, the resident was placed a risk for harm.

Sources: Resident's clinical records, the home's policy titled "Suicide Assessment, Prevention and Support," last reviewed March 2023, and interview with staff and the DOC. **[740860]**

This order must be complied with by March 26, 2024

COMPLIANCE ORDER CO #002 Requirements on licensee before discharging a resident

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)

Requirements on licensee before discharging a resident s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

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

Specifically, the licensee shall:

1. Ensure the management in the home, and any other persons responsible for discharging a resident, reviews the following legislation:
    a. Ontario Regulations, 246/22, s.156 related to "Restriction on discharge."

   b. Ontario Regulations, 246/22, s. 157 related to "When licensee may discharge."

   c. Ontario Regulations, 246/22, s. 161 related to "Requirements on licensee before discharging a resident."

2. Document and maintain a record of the review of the legislation outlined in part 1. including the date and time the review occurred, the names, title, and signature of who participated in the review, and the name of the person who conducted the review.

3. Upon review of the regulations, the Licensee must conduct a thorough review and revision of their Discharge policy, to ensure that it aligns with all regulatory requirements outlined in O.Reg. 246/22 as it pertains to discharges; and,

   a. The home's revised policy must include the date it was reviewed and revised, including the names of those who participated in the review and revision, and the signature of the person approving the policy.

   b. Provide education of the home's Discharge policy to the Physician and maintain record of this education including the name of the person who provided the education, and the date and time the education occurred.

Grounds

The licensee failed to ensure that a resident was given the opportunity to participate in their discharge planning and that their wishes taken into consideration before being discharged from the home.

Rationale and Summary

On a specified date, the resident's clinical records showed that they were removed from the home's following a transfer to the hospital.

The resident was discharged from the home based on the leaderships' decision that the resident's care needs had changed and that the home could no longer provide care safely to the resident. There were no referrals made to the appropriate care coordinator prior to their discharge.

The resident stated that they were not aware that they were being discharged from the home and expressed concerns. The Administrator acknowledged that they did not provide a formal notification to the resident of their discharge.

The resident was also refused to return to the long-term care home by the home.

The resident's family member stated that they were informed by the DOC about the resident's transfer to hospital via telephone and that the resident would not be able to return to the home. This was acknowledged by the DOC.

The home's policy for "Discharge," last reviewed January 2022 stated that a resident/Substitute Decision-Maker (SDM), and any person either of them may direct, will be kept informed and given the opportunity to participate in the discharge and their wishes will be considered.

When the home failed to provide the resident an opportunity to participate in the discharge planning and ensure that their wishes were taken into consideration, the resident was negatively impacted as they were left with no permanent accommodation, and without any of their personal belongings.

Sources: Resident's clinical records, the home's policy, titled "Discharge," last reviewed January 2022, interview with resident, the resident's family, the DOC, ASSC, the Administrator, Physician, Manager of Access and Flow Niagara Health, and Patient Services Manager for HCCSS. **[740860]**

This order must be complied with by March 27, 2024

COMPLIANCE ORDER CO #003 Requirements on licensee before discharging a resident

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)

Requirements on licensee before discharging a resident s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

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

1. The home must contact the resident at the earliest time possible, to:
   a. Answer any questions and concerns the resident may have; and
   b. Collaborate with the resident to determine a plan for the safe storage and transfer of their personal belongings; and
   c. Obtain information from the resident whether the resident would like their family to be provided a written notice of discharge; and
   d. The conversation must be documented including the home's actions taken to address the resident's concerns and wishes in the resident's

clinical records by the person who contacted the resident, on the day that the resident was contacted.

2. The home must provide the resident, and any person that they may direct, a written notice of the resident's discharge. This written notice must include a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justifies the licensee's decision to discharge the resident; and
3. This written notice must be couriered to the resident, and any person the resident may direct, and a copy of the written notice provided to the resident must be kept in the resident's clinical records and be readily available for MLTC inspector review.

Grounds

The licensee failed to provide a written notice to the resident, or any person the resident may direct before the resident’s discharge from the home in accordance with regulatory requirements.

Rationale and Summary.

The resident was sent to the hospital on a specified date and was discharged from the home on the same day.

As per the Administrator, the home in collaboration with the resident’s physician determined that the resident’s care needs had changed, and that the home was not able to provide care for the resident safely.

A review of the resident’s clinical records showed no information that a written notice was provided to the resident or anyone they may have directed about the discharge. The Administrator acknowledged that a written notice of the resident’s

discharge was not provided prior to, and after the resident had been discharged from the home.

The home's policy, titled "Discharge," last reviewed January 2022, outlined that the Administrator/Director of Care/designate must provide written notice to the resident and / or the resident's SDM which includes a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements of care, that justify the home's decision to discharge the resident, which aligns with the regulatory requirements.
By not providing a written notice to resident and whomever they may direct, the resident was not provided the opportunity to take part in their discharge planning, or to find appropriate supports towards discharge.

Sources: Resident's clinical records, the home's policy, titled "Discharge," last reviewed January 2022, and interview with resident, resident's family, the DOC, and the Administrator. **[740860]**

This order must be complied with by March 6, 2024

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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.