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: March 30, 2023

Inspection Number: 2023-1149-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Blackadar Continuing Care Centre Inc.

Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.04.04 13:11:25 -04'00'

Additional Inspector(s)
Emmy Hartmann (748)
Karlee Zwierschke (740732)

INSPECTION SUMMARY

The inspection occurred on the following date(s):

January 16-18, 20, 23-27, 30, 31, February 2, 3, 6-9, 13-15, 17, 27, 28, March 1-3, 6-8, 2023, with January 25, 2023, being offsite.

The following intake(s) were inspected:

- Intake: #00001242 - Complaint regarding housekeeping, pest, mold, skin care, care plans, abuse/neglect, unsafe transfers
- Intake: #00003367 - Complaint regarding certification of nurses
- Intake: #00003765 - Complaint regarding nursing and personal support services & emergency plans
- Intake: #00005059 - Complaint regarding the home during a power outage
- Intake: #00006635 - Complaint regarding the prevention of abuse and neglect.
- Intake: #00002441 - CIS: 2641-000016-22 - Prevention of abuse and neglect.
- Intake: #00007718 - CIS: 2641-000003-22 - Unexpected death.
- Intake: #00008662 - CIS: 2641-000019-22 - Fall resulting in injury.
- Intake: #00019170 - CIS: 2641-000002-23 - Late reporting, prevention of abuse and neglect.

The following intakes were completed in this inspection:

- Intake: #00001452 (CIS: 2641-000014-22), Intake: #00004717 (CIS: 2641-000010-22), and Intake: #00013656 (CIS: 2641-000022-22) related to falls prevention management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee shall implement, any standard or protocol issued by the Director with respect to infection prevention and control.

A. Section 6.1 of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states, the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.

The licensee failed to ensure that PPE was available at point of care for two residents on additional precautions.

Rationale and Summary:
During observations made on January 16 and 18, 2023, yellow PPE bags were not available on the doors of two residents identified as being on additional precautions.

In a follow-up observation on January 24, 2023, it was observed that yellow PPE bags were available on the doors of those residents. The Director of Care (DOC) reported the expectation is that PPE is available on the doors of all residents on additional precautions.

There is risk staff would not wear the appropriate PPE when providing care if it was not readily available and accessible.

Sources: Observations, interview with the DOC and IPAC Standard for Long-Term Care Homes (April 2022).
Date Remedy Implemented: January 24, 2023

B. Section 10.1 of the IPAC Standard for Long-Term Care Homes states, the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

The licensee failed to ensure that 70-90% ABHR was in use in the home.

Rationale and Summary:
On January 16, 2023, two bottles of Isagel ABHR with 60% ethyl alcohol were observed to be in use in the home. Additional boxes of the Isagel 60% ABHR were observed in a storage area. On January 27, 2023, the DOC confirmed the Isagel was in use and had found and removed four bottles from the home for disposal and that the additional ABHR in the storage area would also be disposed of.

There is risk that using ABHR with less than 70-90% alcohol may not be effective in reducing disease transmission.

Sources: Observations, interview with the DOC and IPAC Standard for Long-Term Care Homes (April 2022).

Date Remedy Implemented: January 27, 2023
[741071]

WRITTEN NOTIFICATION: Plan of Care: Clear Direction

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The licensee failed to ensure that the care set out in a resident's plan of care provided clear direction to the staff.

Rationale and Summary:
A resident's documented Advance Directive had a physician note written beside it that stated directions that were not consistent with the advance directive.

The Long-Term Care Consultant reported that the expectation for registered staff is to follow residents plan of care and their advance directives, and that the resident's plan of care was not clearly documented.

Due to the discrepancies in the residents Advance Directive and the handwritten physician note, the plan of care was not clearly documented for the staff providing resident care.

Sources: Investigation notes, the resident's Advanced Directive and interview with the Long-Term Care Consultant.
[741071]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 76 (2) 8.

The licensee has failed to ensure that a staff member was trained in the home's emergency medical policies and procedures.

Rationale and Summary:
The DOC was unable to provide documentation to support that a staff member received training in the homes medical emergency/Code Blue Policy during their employment with the home.

Failing to train the staff member in the homes emergency medical policies and procedures, may impact the staff's response in a medical emergency.

Sources: Interview with the DOC, Code Blue Policy: EP-05-01-01-2022 and employee file.
[741071]

WRITTEN NOTIFICATION: Based on Assessment of Resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on the preferences of the resident.

Rationale and Summary:
A resident's care plan identified that they preferred a specific method of bathing, however, the resident informed the inspector that was not their preference.

The DOC verified that staff used the care plan to obtain directions for resident care; and that the resident's care plan should have been updated with the resident's current preferences.

Sources: Resident's care plan, and Kardex; interview with the resident, and DOC.
[748]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:
The care plan for a resident listed specific falls interventions that were not observed to be in place. A staff member confirmed that the interventions were not in place as per the care plan.

Not having the falls interventions in place as per the care plan, put the resident at risk of injuries if the resident had fallen.

Sources: Resident's clinical record, interview with staff and observations.
[740732]

WRITTEN NOTIFICATION: Documentation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident's bathing.

Rationale and Summary:
The resident was to have their bathing completed twice a week. There was no documentation for the resident's bathing on two occasions.

The resident identified that they received bathing twice a week and had no concerns about not receiving the care they needed.

The DOC verified with staff that the resident received bathing care on those days however, the staff did not document the provision of care.

Sources: The resident's care plan and Kardex; interview with the resident, and DOC.
[748]

WRITTEN NOTIFICATION: When Reassessment, Revision is Required

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the resident's plan of care was updated to reflect the current altered skin integrity requiring interventions or treatment.

Rationale and Summary:
The DOC identified that the care plan provided direction to staff related to the resident's care needs. The resident's care plan identified that they had multiple areas of altered skin integrity. The Wound Care Lead identified that several areas had resolved but their care plan was not updated.

The Wound Care Lead acknowledged that the care plan should have been updated on the dates that the altered skin integrity was resolved, so that the document reflected the current plan for the resident and directions to staff.

Sources: The resident's care plan and interview with the Wound Care Lead.
[748]

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed to ensure that a resident was reassessed, and their plan of care revised when care set out in the plan was not effective.

Rationale and Summary:
A resident sustained a fall that resulted in an injury on a day in September of 2022. The resident's clinical record indicated that they had multiple falls over a three-month period before the fall in September of 2022.

A review of the resident's written plan of care in place in September of 2022, indicated that they were at a high risk for falls and had several interventions in place. The falls prevention interventions in the care plan were implemented in 2019 and had not been revised after the multiple falls in 2022. The resident's written plan of care was not revised until after the fall in September of 2022, as confirmed by the DOC.

The resident was placed at risk of harm when their written plan of care was not revised when falls prevention interventions were not effective after multiple falls.

Sources: The resident's clinical record and interview with the DOC.
[740732]

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home has an infection prevention and control (IPAC) lead whose primary responsibility is the home's infection prevention and control program.

Rationale and Summary:
The DOC confirmed that the home did not have an IPAC lead and although the DOC had been assuming the IPAC lead responsibilities, it was not their primary focus.

There is risk that by failing to have an IPAC lead, IPAC responsibilities will not completed, which may impact the health and wellbeing of the residents and staff.

Sources: Interview with DOC and IPAC Lead job posting.
[741071]

WRITTEN NOTIFICATION: Duty to Protect

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

Rationale and Summary:
Ontario Regulation 246/22, defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

The resident reported that a staff member was rough with them while they were being assisted. The home's investigation notes identified that abuse was substantiated, and disciplinary action was taken on the involved staff. The DOC verified that the resident was abused by staff.

There was impact to the resident as they were noted to be crying and upset after the incident.

Sources: Resident's progress notes, the home's investigation notes and interview with the DOC.

[748]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report a suspicion of abuse and the information it was based upon to the Director.

Rationale and Summary:
Ontario Regulation 246/22 defined emotional abuse as "any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences".

An incident was witnessed where one resident spoke inappropriately to another resident. The DOC identified that the resident performing the gesture understood the communication they made and the consequences.

The home’s internal process was not followed, resulting in the home failing to report to the Director as required.

Sources: Resident progress notes; the home's investigation notes, the home's Abuse policy, last reviewed January 2022.
[748]

WRITTEN NOTIFICATION: Directives by Minister

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister’s Directive that applies to the long-term care home, the Minister’s Directive was complied with. In accordance with the Minister’s Directive: COVID-19 response measures for long-term care homes, the licensee must complete IPAC audits every two weeks unless in outbreak and when a home is in outbreak, IPAC audits must be completed weekly.

The licensee has failed to ensure that IPAC self-audits were completed as required.

Rationale and Summary:
IPAC self-audits were not completed as required for the five weeks between October 13 and November 23, 2022 and for the seven weeks between November 23, 2022 and January 18, 2023.

Failure to complete IPAC self-audits as required, may increase the homes risk of outbreak and/or the ability to identify factors to manage an outbreak.

Sources: IPAC self-audits and interview with the DOC.
[741071]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure that the home's falls prevention and management program was followed, specifically where staff were required to complete a post-fall assessment and clinical monitoring record for 72 hours.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a falls prevention and management program which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program" reviewed January 2022.

Rationale and Summary:
Progress notes for a resident indicate that they had an unwitnessed fall. The homes Falls Prevention Program policy required staff to complete a post-fall assessment after each fall and complete the clinical monitoring record for 72 hours after an unwitnessed fall. The DOC confirmed that no post-fall assessment was completed after the resident fell, and the clinical monitoring record was not completed for the full 72 hours as required by policy.

Not completing the required assessments post-fall placed the resident at risk of complications from the fall that could have been identified through the required assessments.

Sources: Resident's clinical record, interview with DOC and Falls Prevention Program Policy (RC-15-01-01).
[740732]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that the resident received an assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary:
The home's policy stated to use clinically appropriate assessment tools for residents exhibiting altered skin integrity.

The Wound Care Lead identified that instead of using the correct clinically appropriate instrument to assess the resident's wound, staff used another wound assessment instrument that was not the correct tool for the resident's wound. The Wound Care Lead also verified there was no measurement of the wound during this assessment.

The resident's wound was at an increased risk of not receiving the appropriate treatment; as the weekly re-assessment completed, did not give a good indication of the status of the wound.

Sources: Resident's care plan, wound assessments, the home's Wound Care Management policy, last reviewed January 2022, and interview with Wound Care Lead.
[748]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.

The licensee has failed to comply with their written approaches to care, to meet the needs of a resident.

Rationale and Summary:
In accordance with Ontario Regulation 246/22 s.11. (1) b, the licensee was required to ensure that their responsive behaviour policy was complied with.

Specifically, staff did not comply with the “Responsive Behaviour Huddle" policy, which was captured in the home's Responsive Behaviour program.

The policy stated that when there was a new responsive behaviour episode or an escalation in a previously identified behaviour, a responsive behaviour huddle would be done and documented in the debrief tool. A review and update of the care plan integrating the new information obtained as a result of the responsive behaviour, would then be completed, as part of the huddle.

In review of the resident's progress notes, there were numerous escalations in the resident's behaviour identified where the responsive behaviour debrief tool was not completed.

The DOC verified that there should have been responsive behaviour huddles and debriefs completed for the escalation in the resident's behaviours.

There was a risk that the resident's plan of care to manage their behaviours was not up to date as a responsive behaviour huddle and debrief were not completed.

Sources: Resident's progress notes, assessments, and care plan; the home's Responsive Behaviour policy, last reviewed January 2022; interview with the DOC.
[748]

COMPLIANCE ORDER CO #001 Wound Assessments

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 55 (2) (b) (iv) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

The licensee shall prepare, submit, and implement a plan to ensure specific residents’ altered skin

integrity are reassessed at least weekly by a member of the registered nursing staff.

The plan must include but is not limited to:

- The necessary corrective actions, and the person(s) responsible for implementing them.
- The type and frequency of quality monitoring, including who will be responsible and how it will be documented.
- How the plan will be evaluated and reassessed for effectiveness, and the frequency of the evaluations.
- Strategies to address non-compliance with the plan and who will be responsible for this.

Please submit the written plan for achieving compliance for inspection 2023_1149_0003 to Pauline Waldon, LTC Homes Inspector, MLTC, by email to HamiltonDISTRICT.MLTC@ontario.ca by April 17, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

This plan shall be implemented by the compliance due date: April 17, 2023.

Grounds:

Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to ensure that several residents' altered skin integrity were reassessed at least weekly by a member of the registered staff.

Rationale and Summary:

A. A resident had multiple areas of altered skin integrity.

A review of the assessments for the resident's altered skin integrity identified:

- A gap of 18 days in the assessment of the one of wounds.
- A gap of 14 days in the assessment of the same wound.
- A gap of 31 days in the assessment of another wound.

The wound care lead for the home confirmed that the resident's wounds should have been assessed at least weekly; however, the weekly assessments were not completed.

There was an increased risk of worsening of the resident's altered skin integrity, as they were not assessed weekly.

Sources: Resident's progress notes, wound care assessments and interview with the Wound Care Lead. [748]

B. Another resident developed a wound that was initially assessed however, no other subsequent re-assessments of the wound were conducted.

The Wound Care Lead confirmed that there were no other assessments of the wound and that the wound had deteriorated.

There was a risk that the resident did not get the care they needed related to wound care as the wound was not re-assessed on a weekly basis.

Sources: Resident's progress notes, care plan, wound assessments, and interview with DOC.
[748]

C. Another resident had two wound areas. The Wound Care Lead identified that the assessments for altered skin integrity were to be completed on a weekly basis. A review of the weekly wound assessments identified that an assessment scheduled for one of resident's wounds was not completed. In addition, two assessments scheduled for the resident's other wound were also not completed.

The Wound Care Lead verified that the wounds were not assessed at least weekly.

There was risk of a delayed implementation of interventions for the resident's skin impairment, as there was no weekly re-assessment of the status of their skin.

Sources: Resident's care plan, wound assessments; interview with Wound Care Lead.
[748]

D. Another resident had an order for a specific wound assessment weekly for one wound area and another assessment weekly for another wound area. The assessments were not completed for four weeks over an eight-week period for the first wound area and were not completed for a consecutive 13 weeks for the second wound area.

The assessments of the first wound indicated the wound had increased in size and the condition of the wound had deteriorated, although the wound was also documented as being stable/stalled on these assessments.

Both the Quality/Wound Care Lead and Long-Term Care Consultant confirmed that the resident's wounds had not deteriorated and were stable.

By not completing the weekly assessments, there is risk that the resident's wounds could deteriorate and not receive appropriate treatment.

Sources: Resident's orders, wound assessments, progress notes and interviews with the Long-Term Care Consultant and Quality/Wound Care Lead.
[741071]

E. Another resident had an order to complete a weekly wound assessment of their wound area. Wound assessments were not completed for four of the weeks over an eight-week period. There was no documented change in the resident's wound during this time.

There is a risk that a change in the resident's wound could go unnoticed if the wound assessments were not completed as required.

Sources: Resident's orders, wound care assessments, progress notes and interview with the Long-Term Care Consultant.
[741071]

This order must be complied with by April 17, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

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

Compliance History:

October 27, 2021, CO issued under O. Reg. 79/10 s. 50 (2) (b) (iv)

This is the first time the licensee has failed to comply with this requirement.

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

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.