Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 12, 2024
Original Report Issue Date: January 11, 2024
Inspection Number: 2023-1123-0003 (A1)
Inspection Type: Proactive Compliance Inspection
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Bon Air Long Term Care Residence, Cannington

Amended By	**Inspector who Amended Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2024.02.13 15:36:46 -05'00'

AMENDED INSPECTION SUMMARY

This inspection report has been amended to:
NC #002 - O. Reg. 246/22, s. 12 (1) 3. Doors in a home – revision to the last paragraph's statement of risk,
NC #003 - O. Reg. 246/22, s. 19. Windows – revision of the sources to amend incorrect date,
NC #004 - O. Reg. 246/22, s. 79 (1) 5. – Dining and snack service – revision of the findings to amend food management company to long-term care management company,
NC #006 - O. Reg. 246/22, s. 26. Compliance with manufacturers' instructions – revision to the findings, including the home's action of initiating the use of the daily disinfectant checks.

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Long Term Care Home and City: Bon Air Long Term Care Residence, Cannington	
Lead Inspector April Chan (704759)	**Additional Inspector(s)** Sharon Connell (741721)
Amended By April Chan (704759)	**Inspector who Amended Digital Signature** April W Chan Digitally signed by April W Chan Date: 2024.02.13 15:37:04 -05'00'

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NC #006 - O. Reg. 246/22, s. 26. Compliance with manufacturers' instructions – revision to the findings, including the home's action of initiating the use of the daily disinfectant checks.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-7, 11, 12, 14, 15, 2023
The inspection occurred offsite on the following date(s): December 18, 2023

The following intake(s) were inspected:
Intake #00102758 - PCI inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

AMENDED 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 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure a resident's plan of care was revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary

The resident had cognitive and physical impairments and required extensive assistance for their care. The resident's plan of care identified that they required specific care.

Interview with a Personal Support Worker (PSW) indicated that the resident required care that was not specified in the plan of care. The Director of Care (DOC) and Resident Assessment Instrument (RAI) coordinator was informed of discrepancies of

the resident's plan of care and care provided. The DOC acknowledged that they interviewed direct care staff and that the plan of care was revised to reflect the residents care needs. RAI Coordinator confirmed the resident's plan of care was revised on December 15, 2023.

There was minimal risk identified when the resident's plan of care was not revised when the resident's care needs change or care set out in the plan was no longer necessary.

Sources: clinical record, interviews with the DOC, RAI Coordinator and other staff. [704759]

Date Remedy Implemented: December 15, 2023

(A1)
The following non-compliance(s) has been amended: NC #002

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 has failed to ensure that four doors leading to non-residential areas were locked in a way to restrict unsupervised access to those areas by residents, and those doors be kept closed and locked when they are not being supervised by staff.

Rationale and Summary

During initial tour, the housekeeping room, linen room, mud room were observed closed and locked, however keys that opened the doors were hung by fabric or coiled lanyards and was kept next to the doors. A salon room door was observed closed and unlocked with the key left in the key cylinder. The mud room had access to an unsecured, bottom-hinged linen chute that led to the basement. Materials kept inside these rooms included an opened jar of barbicide, rolling stools, odour eliminator, alcohol rub, housekeeping disinfectants and cleaning solutions.

The Safe and Secure Home policy stated that doors leading to non-residential areas must be locked to restrict unsupervised access to those areas by non-staff.

A staff member indicated that mud room, linen room, housekeeping room doors were meant to be kept locked and that residents were not allowed in those areas. The staff member indicated that the keys hung on lanyards were kept next to the doors to prevent missing or lost keys. A Registered Practical Nurse (RPN) indicated that the key left in key cylinder of the salon room door was a mistake by another staff member and that the key was to be stored at the nursing station. The RPN promptly removed the key from the salon room door. The Executive Director (ED) acknowledged the mud room, linen room and housekeeping room doors should be locked and the keys not accessible to residents, and promptly removed the hanging keys. The ED indicated that keys hung on the coiled lanyard was worn and meant to retract so that residents cannot access it.

There was risk to resident safety identified when four doors leading to non-residential areas was not locked in a way that was secure to restrict unsupervised access to these areas by residents.

Sources: observations, Safe and Secure Home policy, interviews with the ED and other staff. [704759]

(A1)
The following non-compliance(s) has been amended: NC #003

WRITTEN NOTIFICATION: WINDOWS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure three windows in the home that opened to the outdoors and were accessible to residents to be not opened more than 15 centimetres (cm).

Rationale and Summary

During initial tour, two of the three resident bedrooms visited were observed to have windows that opened greater than 15 cm. A resident room had two sliding windows and one of the windows opened greater than 15 cm. Another resident room had two

sliding windows that both opened greater than 15 cm. On a later date, the sliding windows in the two resident rooms were reinspected and were observed to have stoppers installed to restrict the opening width. The window openings were remeasured, and the opening was not greater than 15 cm.

The Safe and Secure Home policy indicated that windows must be designed to prevent entering and exiting the home and not to open more than 15 cm.

A Maintenance worker indicated that they were not aware of the window opening width requirements. The Maintenance worker indicated that they secured the windows following the Inspector's initial observations.

There was risk identified when three windows in the home that opened to the outdoors and accessible to residents opened more than 15 cm.

Sources: observations, Safe and Secure Home policy, interview with a Maintenance Worker. [704759]

(A1)
The following non-compliance(s) has been amended: NC #004

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 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 has failed to ensure that the temperature of food and fluids served to residents was at a safe and palatable temperature.

Rationale and Summary

During a proactive compliance inspection (PCI) lunch meal service observation, soup temperatures were higher than the safe range found in the home's audit binder and hot beverage temperatures were not documented.

A PSW who was assisting a resident to eat, was observed stirring the soup and confirmed they were waiting for it to cool slightly.

A Dietary Aide explained that a safe temperature range for serving food was a minimum of 140˚F and onwards and they regularly reference the food temperature binder for the safe temperature ranges.

The Food Services Manager (FSM) confirmed that the documented soup temperatures were outside the safe temperature range and acknowledged that the soup should be poured out into bowls and left to cool down before serving, to prevent burns.

The Temperature Audit log sheet documentation for the observed lunch meal confirmed that soup temperatures were higher than the standard (safe) range, with a reading of 195˚F to 208˚ F. No temperature measurements were recorded for the tea, coffee and warmed milk.

The safe temperature ranges for soup on the audit sheet and the Meal Service -

Serving of Food policy differed by 10˚F. The audit sheet showed a standard range of 160 to 180˚F and the policy showed a range of 170 to 190˚F.

The long term care management company advised the Administrator that servery staff were using an incorrect audit tool that was meant for the cook and not for the holding/serving temperatures, and that hot beverages did require temperature monitoring. The administrator confirmed that staff should be serving food at the right temperature, and they were in the process of re-training with a new Servery Temperature Form.

Cooling directions were now listed on the new Servery Temperature Form which confirmed that the standard holding temperature for soup was 140˚ F to 169˚ F. Staff had begun recording hot beverage temperatures.

Failure to ensure that the temperature of food and fluids served to residents was at a safe and palatable temperature, increased the risk of skin damage and potential for burns from high serving temperatures.

Sources: Meal service observation, Temperature Audit Sheet, new Servery Temperature Form, Meal Service – Serving of Food policy, and staff interviews. [741721]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented

for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of contact surfaces using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

Staff cleaning and disinfection practices were observed during a meal service observation for a proactive compliance inspection of the home.

A staff member assisting with a meal service was observed to dip the same dish cloth back into the bucket of disinfectant solution while cleaning multiple soiled dining room tables. They confirmed that this was the process for cleaning tables and acknowledged there were two cloths in the disinfectant bucket in case two staff were wiping down tables at the same time.

A Dietary Aide confirmed that the disinfectant bucket sitting on the dish room sink counter had been used to clean the surface of all the food and dish carts that had just returned after use at the meal service. They confirmed testing the disinfectant when it was first poured into the bucket, and then they dip the same dish cloth repeatedly into the same bucket of disinfectant solution until all the soiled carts from the meal service have been cleaned. When they demonstrated the process of

testing the disinfectant strength by dipping the test strip into the bucket they had just used to clean all the food carts, the reading failed to reach the recommended level.

The Food Services Manager (FSM) confirmed that it is the practice of the staff to use the same cloth and continue to dip the cloth back into the disinfectant bucket and acknowledged that once the disinfectant was contaminated by the soiled cloths it would no longer be effective. They confirmed that the meal service cart surfaces would not be sanitized properly if the disinfectant strength was below the recommended level and arranged to have the equipment/meal carts properly sanitized before the next use.

Provincial Infectious Diseases Advisory Committee (PIDAC): Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018, Section 1.3.2.2 - Using Disinfectants: Minimizing the contamination levels of the disinfectant solution and equipment used for cleaning can be achieved by frequently changing the disinfectant solution and wiping cloths, and not dipping a soiled cloth into the disinfectant solution (i.e., no “double-dipping”).

Failing to ensure that cleaning and disinfection of contact surfaces using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, placed residents at increased risk for health care associated infections.

Sources: Observation of cleaning practices, PIDAC: Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018, Section 1.3.2.2 Using Disinfectants, staff interviews. [741721]

(A1)
The following non-compliance(s) has been amended: NC #006

COMPLIANCE ORDER CO #001 COMPLIANCE WITH MANUFACTURERS INSTRUCTIONS

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1. Develop and implement policies and procedures for concentration testing, as per manufacturers' recommendations, of all diluted disinfectants used in the home for cleaning and disinfection of contact surfaces.

2. Keep a record of the concentration testing, including dates, times, results and corrective actions taken in the event of a test failure, and make available to Inspectors immediately upon request.

3. Provide training to assigned staff (i.e. housekeepers, dietary/kitchen staff) on the policies and procedures for concentration testing of all diluted disinfectants, and update training and policies as required for disinfectant product changes.

4. Keep a documented record of this education, including date, content of the education, who delivered the education, name of staff educated and make available to the Inspector immediately upon request.

Grounds

The licensee failed to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions.

Rationale and Summary

During a proactive compliance inspection a disinfectant wall unit was found in the housekeeping closet which was being used to dilute and dispense the general disinfectant used for cleaning and disinfection of contact surfaces in resident areas.

A Housekeeper confirmed that they were expected to test the concentration of the disinfectant dispensed from the wall unit, once a week and record the readings on the ED Concentration Check Tracking Sheet.

The ED Concentration Check Tracking Sheet contained weekly readings of the homes disinfectant concentration levels for the current calendar year.

The manufacturer sent an email to the Administrator, confirming that daily disinfectant concentration checks were recommended to flag any issues and ensure that the disinfectant was meeting the required levels on a daily basis. Based on this recommendation, the home initiated the use of a new audit sheet for disinfectant concentration checks, to be performed and recorded by housekeeping staff daily.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care associated infections.

Sources: Disinfectant dispenser equipment observation, ED Concentration Check Tracking Sheet, manufacturer's recommendations email, staff interviews (Housekeeper, Administrator). [741721]

This order must be complied with by March 29, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. The IPAC lead or trained designate will complete meal or snack time staff hand hygiene audits two times a week for 6 weeks. Over the course of the six-week period the audits will include all three mealtimes and one each of the snack service times, choosing only one of the meal or snack times per audit. Documentation will include the name of the person completing the audit, the meal or snack service

time, the name and job category of the staff that were observed, the hand hygiene moment, whether the hand hygiene was performed correctly, or missed, and any corrective actions taken for incorrect or missed opportunities. Mealtime audits will contain a minimum of 4 hand hygiene opportunities each, for at least four different staff. Snack time audits will contain a minimum of 4 hand hygiene opportunities for each of the staff providing the snack service.

2. All hand hygiene audits will be retained for records and made available to Inspectors, immediately upon request.

3. The IPAC Lead will analyze the overall hand hygiene audit findings from the six-week period to identify trends and create an action plan if deficits are identified. A summary of this analysis and any related action plans will be made available to Inspectors, immediately upon request.

4. Three staff members will attend a hand hygiene audit for one meal service, alongside the IPAC lead or trained designate, which will include instruction on the moments/opportunities for hand hygiene during a meal service. They will participate in making observations alongside the trained auditor but are not required to fill out an audit tool. They must take part in a debrief discussion regarding the audit findings and any corrective actions that were taken. A summary of the debrief discussion will be kept, including participant names, date, and time, and be made available to Inspectors, immediately upon request.

5. Develop a tool, such as a posted sign, to remind staff to practice pulling curtains to separate residents' personal space while a resident requires droplet and contact precautions in a shared room. Ensure that a written procedure is developed to indicate how the tool is implemented and discontinued. Provide a copy of the tool and written procedure to Inspectors immediately upon request.

6. Conduct random audits for residents who require droplet and contact precautions in a shared room, to ensure practices to separate residents' personal space are implemented, for a period of two weeks. Maintain a record of the audits completed, including but not limited to, date of the audit, name of the person completing the audit, name of staff and resident audited, outcome and actions taken as a result of any deficiencies identified. Provide the record of the audits to Inspectors immediately upon request.

Grounds

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

1. The licensee failed to ensure that routine practices including hand hygiene were followed by staff members in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), last revised September 2023. Specifically, hand hygiene after resident and resident environment contact was not performed as was required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

Staff hand hygiene practices were observed on two separate days, while conducting a meal service observation for a proactive compliance inspection of the home.

A PSW was observed discarding soiled items and lifting garbage and soiled linen hamper lids, and then returning to touch clean items still in use by residents, with no

hand hygiene performed in between. They were also seen adjusting their mask regularly without sanitizing their hands and then assisting residents or serving food. On a second day they failed to sanitize their hands after removing soiled dishes from one resident and then helping a different resident to eat their food.

Staff #122 and #123 were observed rubbing the alcohol hand rub off their hands, after a rushed hand hygiene moment. One wiped their hands on their apron and the other used a paper towel. The Director of Care (DOC) intervened and asked for staff #123 to be told not to use a paper towel to dry off the alcohol rub from their hands.

The DOC confirmed that staff were expected to perform hand hygiene after clearing plates or wiping a resident's nose, or anytime there was a risk of bodily fluid contact. They acknowledged that the PSW should have performed hand hygiene after clearing the dirty dishes and before helping the other resident to eat their meal.

Public Health Ontario (PHO) Four Moments of Hand Hygiene training certificates were produced by the home for staff #122 and #123. This training instructs learners that hand hygiene should be performed for a minimum of 15 seconds and is indicated before and after each activity in a shared or group setting.

Failure to perform the four moments in hand hygiene, increased the risk of health care associated infections.

Sources: meal service hand hygiene observations, PHO - Four Moments of Hand Hygiene training, DOC interview. [741721]

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

2. The licensee failed to ensure that evidence-based practices, including separating a resident's personal space for a resident requiring Droplet and Contact Additional Precautions while in a shared room, were followed in the IPAC program in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes, revised September 2023" (IPAC Standard). Specifically, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program as is required by Additional Requirement 9.1 under the IPAC Standard. At a minimum, Additional Precautions a) and b) shall include evidence-based practices related to potential contact and droplet transmission and required precautions.

Rationale and Summary

A resident's room was observed with a posted sign outside of the door indicating droplet and contact additional precautions with use of N95 respirator. The resident's room was a two-bed, semi-private, shared room between a symptomatic resident and another co-resident. The two beds were observed facing the same wall, situated side by side, and close together. There were curtains in the room, but they were not drawn in between the beds. The resident requiring additional precautions was seated in a wheelchair inside their room beside their bed and their co-resident neighbour was not inside the room at the time.

The Droplet Contact Precautions policy indicated that infectious agents have a primary mode of transmission but may also have a secondary mode of transmission. The policy noted that respiratory viruses may remain viable for some time in droplets that settled on objects in the immediate environment of the resident. The policy indicated that for accommodations, if a resident required Droplet Contact Precautions while in a shared room, the privacy curtains are kept pulled to separate the residents' personal space.

Interview with an RPN indicated that they had not seen curtains pulled between the bed during the day and indicated that curtains should be drawn between the beds. IPAC manager indicated that practices from public health standards included keeping resident beds in a shared room under Additional Precautions physically distanced at six feet apart, however, the size of the semi-private rooms made it difficult to do and acknowledged that the two beds were not placed six feet apart. IPAC manager acknowledged that curtains in the resident's room should be drawn by direct care staff between the two beds because it acted as a barrier to infectious disease transmission.

There was risk identified when practices related to separating a resident's personal space in a shared room on droplet and contact additional precautions were not followed.

Sources: observations, Droplet Contact Precautions policy, interviews with IPAC manager and relevant staff. [704759]

This order must be complied with by March 29, 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.