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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: June 19, 2024	
Inspection Number: 2024-1301-0003	
Inspection Type: Complaint Critical Incident	
Licensee: The Glebe Centre Incorporated	
Long Term Care Home and City: Glebe Centre, Ottawa	
Lead Inspector Jessica Nguyen (000729)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 30, 2024, and May 1-3, 6-9 and 14, 2024.

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

- Intake #109419 -was related to infection prevention and control and care concerns.
- Intake #109642 -was related to neglect and care concerns.
- Intake #114630 -was related to skin and care concerns.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake #110284/ CI # 2811-000011-24- was related to alleged resident to resident physical abuse.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to the staff who provide direct care to that resident.

Summary and Rationale

During an interview with the resident, the resident explained their toileting needs and that staff don't always check them and some days their perineal care gets missed.

During interviews with different Personal Support Workers (PSW) they stated that the resident's toileting needs change and that the resident can be both independent or dependent for toileting and personal care. Registered Practical Nurse (RPN) confirmed that the resident's care needs fluctuates, and agreed the written care plan was not clear specifically to the resident's toileting and personal hygiene needs.

Failing to ensure the written plan of care for the resident set out clear directions to staff and others who provided direct care to the resident regarding their toileting and personal care needs, put the resident at risk of having their care needs being unmet.

Sources:

Resident's written plan of care.
Interviews with resident, PSWs and RPN.

[000729]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Summary and Rationale

A) The Director of Care (DOC) received a written complaint by email regarding care concerns for a resident. The complaint stated that the resident was found on a specific date without their assistive device, or their specific continence brief as specified in their care plan.

Review of resident's care plan indicated that the resident required assistance for toileting and wore a certain size of incontinence product. It also stated that the resident required assistance with their assistive device, and they were to have them between certain hours of the day.

During an interview with the DOC, it was confirmed that after an internal investigation, allegations were founded, and staff did not provide care to the resident as specified in their plan.

Failing to follow the plan of care placed resident at risk for decreased comfort.

Sources:

Resident's plan of care.
Interview with DOC.
Written complaint submitted.

[000729]

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

B) On a specific date an incident of alleged physical abuse occurred between two residents, which resulted in one resident sustaining an injury.

Review of resident's progress notes for the week prior to the incident, indicated multiple notes stating the need for constant 1 on 1 supervision due to resident's responsive behavior's towards co residents and staff.

The physician had ordered ordered a 1:1 sitter for one resident.

During an interview with Behavioral Supports Ontario (BSO) Champion, it was confirmed that there was no 1:1 sitter working at the time of incident due to staffing constraints.

Failing to ensure that one resident had a 1: 1 sitter present at all times as specified in their plan of care put the other resident and other residents at risk of harm.

Sources:

Resident's paper chart and electronic record.
CI #2811-000010-24.
Interview with BSO Champion.

[000729]

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

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

Summary and Rationale

The resident was scheduled to have their incontinent product changed at specific times as set out in their plan of care.

The point of care (POC) documentation for the resident showed that for a specific month, there was a day where resident's toileting and both incontinent product changes were not documented, and several days where the one toileting and incontinent product changes were not documented.

The (POC) documentation for the resident showed that for another specific month, there was one day where the toileting and incontinent product changes were not documented.

During an interview RAI Coordinator, they confirmed that the staff on the specific dates did not complete documentation for the assigned tasks and that is why they were blank. They stated that toilet use should never be left blank or charted as not applicable because it includes changing of incontinent briefs and if staff left it blank, they are saying they didn't change the resident.

Sources:

Resident's electronic records.
Interview with RAI Coordinator.

[000729]

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect one resident from physical abuse by another resident.

Summary and Rationale

Physical abuse is defined by O. Reg. 246/22 s. 2 (1) as the use of physical force by a resident that causes physical injury to another resident.

Shortly after admission of one resident to the home, an incident of alleged abuse occurred between that resident and another resident, which resulted in one resident sustaining an injury.

Progress notes on day of incident indicated that one resident was agitated and restless the entire night and was entering other co resident's rooms.

Review of one resident's progress notes for week prior to incident, indicated one resident was responsive behaviors and on certain days, these behaviors also included incidents of physical aggression towards other co residents and staff.

According to progress notes, hourly rounding was initiated due to safety concerns for one resident and their room mate due to their unpredictable behaviors. Resident was described as a high risk for safety for themselves and others and required constant monitoring. Physician had ordered a 1:1 sitter on all shifts for one resident.

During an interview with BSO Champion, it was confirmed that although one resident was displaying behaviors prior to incident, there was no 1:1 sitter scheduled at the time of the incident due to staffing constraints.

No immediate actions were taken on one resident in order to protect the other resident and other residents on the unit from further physical abuse. One was found in another resident's room a few hours after incident and the scheduled 1:1 sitter was not with resident at the time, they were later sent to the hospital to treat their medical needs.

During an interview on with RPN, it was confirmed that one resident was sent to the hospital and did not return to the home for several weeks. RPN also confirmed that one resident was found in another resident's room couple of hours after incident and 1:1 sitter was not with the resident at the time. The RPN had to go call them from dining room to stay with the resident.

Failing to take immediate actions put one resident and other residents on the unit at risk of harm / injury.

Sources:

Resident's electronic records and paper chart.
Interview with BSO Champion and RPN.
CI #2811 000010-24.

[000729]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

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

The licensee has failed to immediately forward to the Director a written complaint received regarding care concerns for a resident.

Summary and Rationale

The Director of Care (DOC) received a written complaint by email regarding care concerns for a resident. The complaint stated that the resident was observed without their assistive device and was not wearing the specific continence product as specified in their care plan.

A review of the licensee's Policy 1.00: Concerns and Complaint, last revised September 2022, stated as part of the complaints process, any written complaint received regarding the care of a resident shall immediately be forwarded to the Director.

The DOC was unaware of the requirements in the legislation regarding forwarding all written complaints regarding care concerns immediately to the Director and confirmed this was not completed.

Failing to submit the written complaint immediately to the Director puts the resident at risk of an incident regarding their care going unreported.

Sources:

Interview with DOC.
Policy 1.00: Concerns and Complaint, last revised September, 2022.

[000729]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 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 has failed to ensure that the alleged abuse of a resident by another resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Summary and Rationale

On a specific date an incident of alleged abuse occurred between two residents which resulted in one resident sustaining an injury. The incident was not immediately reported to the Director, the after-hours line was called several hours later and the CI was submitted to the Director the next day.

Failing to immediately notify the Director of the alleged abuse places the resident and other residents at risk of additional harm.

Sources:

CI #2811-000010-24,
Interview with DOC.

[000729]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Summary and Rationale

On a specific day, the resident presented to the hospital for a routine appointment where the nurse observed the resident presented with a health ailment. The resident was admitted for several weeks to the hospital after the appointment.

Review of resident's electronic records indicated a task for assessment to be completed by PSWs every shift but did not indicate any assessment completed by a registered staff or any documentation by a registered staff regarding resident's condition prior to or after hospital admission.

During an interview with RPN, it was confirmed that registered staff did not complete regular assessments on residents after medical appointments and only complete an assessment if there was any noted health ailment.

During an interview with the resident, they stated that the registered staff did not routinely assess resident upon return from hospital appointments and that the day the resident was admitted to hospital, no staff at the home had noticed any health ailment. Concerns were also raised by the hospital regarding how this could have been missed.

Failing to ensure the resident received an assessment by a registered nursing staff using a clinically appropriate assessment instrument placed resident at risk for infection and harm.

Sources:

Resident's electronic chart.
Interview with resident and RPN.

[000729]

WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that resident's skin was reassessed at least weekly by a member of the registered nursing staff.

Summary and Rationale

On a specific day, the resident presented to the hospital for a routine appointment where the nurse observed the resident presented with a health ailment. The resident was admitted for several weeks to the hospital after the appointment. The resident returned to the home with several dressings.

During an interview with the resident, the different dressings were observed. The resident stated that registered staff did not regularly assess either dressing and only changed the specific dressing upon request or on shower days, and since resident had been refusing showers, the dressing had only been changed a few times since their hospital discharge.

Review of resident's electronic Medication Administration Record (eMAR) indicated there was no task to assess or to change the dressings at all. Review of resident's progress notes did not indicate any progress notes related to assessments or dressing changes by registered staff.

During an interview with an RPN, they confirmed there was no new task in the eMAR for assessing or changing either of the dressings, and therefore it was not being completed.

Failing to ensure that the resident received at minimum a weekly assessment by a registered staff places resident at risk for further infection and harm.

Sources:

Resident's electronic chart (progress notes, eMAR).
Interview with resident and RPN.
Observations.

[000729]

WRITTEN NOTIFICATION: Responsive Behaviors

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident when they were demonstrating responsive behaviors and that the resident's responses to interventions are documented.

On a specific date a resident exhibited physically responsive behaviors towards another resident resulting in that resident sustaining an injury.

Review of resident's progress notes indicated for the week prior to incident, the resident was exhibiting responsive behaviors and on specific days these responsive

behaviors also included incidents of physical aggression towards other co residents and staff.

The physician had ordered 1:1 sitter on all shifts for the resident but atthe time of incident, there was no 1:1 sitter scheduled due to staffing constraints.

Review of resident's progress notes attached to the eMAR indicated PRN medication was given to resident on specific dates but was ineffective. Resident continued to display responsive behaviors and was very hard to redirect. The physician was not contacted for a reassessment or adjustment of medication.

According to progress note, hourly rounding was initiated due to safety concerns for resident and room mate due to their unpredictable behaviors. Resident was described as a high risk for safety for herself and others and required constant monitoring.

Review of resident's Behavioral Support Ontario- Dementia Observation System (BSO-DOS) charting prior to the incident, indicated staff were not consistently filling it out and there were multiple gaps in the charting. On specific dates between specific times were left blank.

The resident was accessed by registered staff and was sent out the hospital to treat their medical needs. According to home's Policy 9.00 Responsive Behaviors last revised February 2023. The acronym P.I.E.C.E.S was to be used to assess for possible causes of resident's behavior. The P stands for physical cause or the 5 D's: Delirium, Disease, Drugs, Discomfort, disability. The possible causes for Delirium are Medicine, microbials, metabolic, myocardial. This assessment was not completed prior to incident.

According to the responsive behavior decision tree outlined in the home's policy, when a resident displays inappropriate or escalating behaviors, the staff were to contact the LTC physician and as warranted: involve police, transfer to emergency

room, and refer to outreach team. This was not completed prior to the incident despite resident displaying escalating and unpredictable behaviors.

During an interview with RPN, it was confirmed that the resident was sent to the hospital to treat their medical needs and did not return to the home for several weeks. RPN admitted that looking back now, the resident's behavior during the seven days prior to the incident was very different than their behavior now.

During an interview another RPN, they confirmed that the physician had never been called regarding resident's responsive behaviors because before the incident resident had never had any altercations with another resident. They also stated that since the resident was a fairly recent admission prior to the incident, there was no baseline to compare their behaviors to, but after the hospitalization, the resident was calmer and no longer had violent outbursts.

Failing to respond to the resident's needs when they were demonstrating responsive behaviors put the resident at risk of having their medical needs not met and put other residents at risk for harm and/or injury.

Sources:

Resident's electronic records and paper chart.
Interview with RPNs.
CI #2811 000010-24.
Policy 9.00 Responsive Behaviors, Last revised Feb 2023.

[000729]

WRITTEN NOTIFICATION: CMOH and MOH

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246 / 22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Summary and Rationale

A) Ministry of Health issued in April 2024 the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings. Under section 3.1- IPAC Measures- additional precautions it states that Alcohol Based Hand Rub (ABHR) is the first choice for hand hygiene when hands are not visibly soiled and must not be expired.

During observations on a specific date in a specific dining room, two bottles of ABHR were observed near the food service area with expiry date of December 2022.

During observations of meal service in the dining room, staff were observed using the expired ABHR to perform hand hygiene and supporting residents to perform hand hygiene with the expired ABHR.

During an interview with IPAC Manager, they stated that audits were being performed to ensure ABHR on the floors were not expired. Upon review by IPAC Manager of the ABHR bottles in dining room, it was confirmed that the expiry date was December 2022, and the bottles were removed.

Failing to ensure that all residents were supported with performing hand hygiene prior to meal service with ABHR that was not expired placed residents at an increased risk of contracting an infectious disease.

Sources:

Observations on of staff in dining room.
Interview with resident lPAC Manager.
Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings. Ministry of Health. Effective April 2024.

[000729]

The licensee has failed to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

B) A respiratory outbreak was declared on a specific unit and a memo was sent out to staff stating all staff must wear a procedural mask while on the unit. The same message was sent out several times.

Ministry of health issued in April 2024 the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings. Under section 3.3- Client / Patient / Resident Restrictions it states to implement universal masking in the suspect outbreak area, for respiratory outbreaks.

During an observation on a specific date on outbreak unit, two registered staff were observed sitting at nursing station eating and talking with no masks on. Recreation staff was observed pushing a resident down hallway with no mask on. During an

interview, RPN confirmed they should have been wearing masks because the unit was on outbreak.

During an observation on another date, on outbreak unit, two PSWs were observed in resident lounge with masks hanging off one ear. One recreation staff in activity room observed with no mask on and an RPN observed sitting at nursing station with no mask on. A PSW confirmed the unit was still on outbreak and the expectation was for all staff to be wearing masks.

During an interview with IPAC Manager, they confirmed that the expectation was for all staff on the outbreak unit to be always wearing a surgical mask and the extra required personal protective equipment when entering isolation rooms. The IPAC Manager confirmed that teaching, audits, and multiple memos have been sent out regarding this and all staff should be aware.

Failing to ensure all staff are following the masking recommendations on the outbreak unit puts staff and residents at an increased risk of contracting and spreading an infectious disease.

Sources:

Observations of staff on outbreak unit.
Internal masking recommendations memo.
Interview with IPAC Manager, RPN, PSW.
Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings. Ministry of Health. Effective April 2024.

[000729]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #012 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)]:

A) Educate all Personal Support Workers (PSWs) working on a specific unit on the different hand hygiene products and the resident and staff hand hygiene requirements during meal service, including requirements of staff to support residents with performing hand hygiene prior to meals, as per evidence based best practice standards.

B) Perform audits on hand hygiene to ensure residents are offered assistance with hand hygiene prior to meal service. Conduct at a minimum, two times a week audits on a specific unit. Audits to be completed on separate days, alternating between different meals (eg. breakfast, lunch and dinner). The audits are to be completed until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

C) Take corrective actions to address staff non-compliance related to hand hygiene as identified in the audits.

D) Keep written records of everything required under steps A, B, C of this

compliance order, and must include; a copy of the education provided, those who attended with dates/times, as well as the name of the person who provided the education, a copy of the audits completed, as well as the name of the person who completed the audits, the dates and times of the audits and the unit and meal that was audited. The written records of A, B, C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure the implementation of a standard or protocol issued by the Director with respect to infection protection and control, specifically section 10.4 (h) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard).

Section 10.4 (h) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard) states the Licensee shall ensure that the hand hygiene program provided support for residents to perform hand hygiene prior to receiving meals and snacks and after toileting.

During observations of meal service in a specific dining room, one resident was observed self propelling into dining room and not being supported to perform hand hygiene, three residents were observed being pushed into dining room and not being supported to perform hand hygiene. One resident was observed by nursing station eating a snack, resident left dining room and came back to eat and was not supported to perform hand hygiene. A resident was observed being pushed into dining room and was not supported to perform hand hygiene prior to meal being served.

During observations of meal service in a specific dining room, it was observed one resident was supported by a PSW to perform hand hygiene with a certainty wipe

and two residents were supported by a PSW to perform hand hygiene with surface cleaner and disinfectant wipes.

During an interview with a resident, it was confirmed that they were not supported with hand hygiene prior to being served their meal.

During an interview with IPAC Manager, it was confirmed that expectation was that staff should be supporting all residents to perform hand hygiene prior to meals. It was clarified that certainty wipes should only be used when someone's hands were visibly soiled and than followed by ABHR, and not to be used as a replacement as they don't contain any alcohol. It was confirmed that there are wipes that can be used instead of ABHR for residents that have difficulty with hand hygiene, but these are not the same as the surface cleaner and disinfectant wipes observed in the dining room.

By failing to ensure that all residents are supported with performing hand hygiene prior to meal service, residents are placed at an increased risk of contracting an infectious disease.

Sources:

Observations of staff in a specific dining room.
Interview with a resident and IPAC Manager.
MLTCIB Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, Sept 2023.

[000729]

This order must be complied with by July 31, 2024.

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.