Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report (A1)

Amended Report Issue Date: March 28, 2023	
Original Report Issue Date: February 24, 2023	
Inspection Number: 2023-1013-0002 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: The Royale Development GP Corporation as general partner of The Royale Developme	
Long Term Care Home and City: Case Manor Care Community, Bobcaygeon	
Lead Inspector Nicole Jarvis (741831)	**Additional Inspector(s)** Patricia Mata (571)
Amended By Nicole Jarvis (741831)	**Inspector who Amended Digital Signature** Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2023.03.28 15:27:43 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This licensee inspection report has been revised to reflect correct IPAC hours and number of resident's affect during outbreak. Also, the following previously issued Compliance Order (CO) that were complied.

The inspection # 2023_1013_0002 was completed on January 16 - 20, 23 -26, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

January 16 - 20, 23 -26, 2023

The following intake(s) were inspected:

Intake: #00007716-[CI: 0958-000009-22], related to Emergency- Fire.
Intake: #00012702-[CI: 0958-000011-22], related to staff to resident abuse.
Intake: #00013966-[CI: 0958-000014-22], related to COVID-19 outbreak
Intake: #00016557, complaint related to abuse/neglect left on bed pan for hours, staffing levels, elevator not working, call bell not working
Intake: #00012954, Follow up to CO #001 from inspection #2022_1013_0001 related to O. Reg. 246/22 s.102.(7)11 issued on October 24, 2022, with CDD on November 14, 2022.
Intake: #00012955, Follow up to CO #002 from inspection #2022_1013_0001 related to O. Reg. 246/22 s. 93 (2)(b)(iii) issued on October 24, 2022, with CDD on November 14, 2022.
Intake: #00012957-Follow up to CO #003 from inspection #2022_1013_0001 related to O. Reg. 246/22 s.102 (2) (b) issued on October 24, 2022, with CDD on November 24, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order (CO) was found to be in compliance:

Order #001 from inspection #2022_1013_0001 related to O. Reg. 246/22 s.102.(7)11 inspected by Nicole Jarvis (741831).

Order #002 from inspection #2022_1013_0001 related to O. Reg. 246/22 s. 93 (2)(b)(iii) inspected by Patricia Mata (571).

Order #003 from inspection #2022_1013_0001 related to O. Reg. 246/22 s.102 (2) (b) inspected by Nicole Jarvis (741831).

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

Staffing, Training and Care Standards

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure residents are protected from abuse by staff.

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

Section 2 of the 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."

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident physical abuse.

The CIR indicated PSW #106 was assisting resident with evening care. The resident refused part of the care and as a result PSW #106 tried to hit the resident's thigh.

In an interview, PSW #105 indicated that PSW #106 was overheard yelling in the resident's room. When PSW #105 intervened, the resident appeared upset and asked if staff are allowed to hit the residents. PSW #106 got close to the resident's face and yelled, "If you have something to say, say it to me". PSW #105 indicated that they reported the resident's concern immediately to RPN #107 and told PSW #106 not to care for resident again. PSW #106 continued to work on the resident home area for approximately 50 minutes. Ten minutes

before the end of PSW #106 shift they were relocated to a different resident home area.

The Director of Care confirmed that PSW #106 was not immediately removed from the home and continue to work within the home after the alleged physical abuse. The expectation of the home is that a staff member is immediately removed from the home pending investigation for any alleged abuse towards a resident.

The home failed to protect resident from abuse by not having interventions put in place after the resident reported alleged abuse.

Source: CIR, Resident record review, Interviews with PSW #105 and Director of Care.
[741831]

WRITTEN NOTIFICATION: Policy to promote zero tolerance
NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with. Specifically, the licensee did not comply with the investigation procedure of their policy.

Rationale and Summary

1. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care, related to an reported alleged staff to resident physical abuse.

The home policy entitled "Prevention of Abuse & Neglect of a Resident, VII-G-10.00" last revised October 2022, refer the Long-Term Care staff to a checklist for responding and investigating alleged abuse.

The checklist states:

The Nurse in charge will immediately:

- Interview all possible witnesses (team members, volunteers, visitors, residents) before shift ends and request written and signed account of the incident.
-Initiate internal incident reporting - investigative details are not to be entered into the electronic documentation system. Provide all investigation reports to DOC/ED.

Within the next 48 hours:
-Continue investigation (including interviews of those team members who wrote statements and begin to collate all information into the investigation Summary Report).

The Director of Care (DOC) confirmed the investigation of the incident was not done in accordance with the licensee's policy and checklist. There were no staff written statements of the event and no continued investigation interviews with the staff and resident involved.

Failing to ensure the investigation was completed by the licensee's policy could have potentially increase the risk of reoccurrence of abuse at the Long-Term Care Home.

Sources: CIR , Resident's Record, the Long-Term Care Investigation Package, Prevention of Abuse & Neglect of a Resident, Vii-G-10.00 (revised October 2022), Prevention of Abuse-Checklist for Investigating Alleged Abuse. VII-G-10.00(b), Interviews with PSW #105 and Director of Care.
[741831]

Non-compliance with: FLTCA, 2021 s. 25 (1)

The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with. Specifically, the licensee did not comply with the policy direction for resident post allegations.

Rationale and Summary

2. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care, related to an reported alleged staff to resident physical abuse.

The home policy entitled "Prevention of Abuse & Neglect of a Resident, VII-G-10.00" last revised October 2022 refer the Long-Term Care staff to a checklist for responding and assessing the resident post allegation of abuse.

The checklist states:

Nurse in charge will immediately:
-Assess victim's safety and emotional and physical wellbeing. If necessary, contact attending practitioner for further assessment.

Within 24 hours:
-If abuse/neglect, at minimum documentation and assessment of resident status each shift. Take a photograph of the resident and the site of injury (not sexual)- frequently bruising does not appear immediately.

The Director of Care stated the resident was assessed at the time of the alleged abuse and there was no indication of bruising or an injury. Although, the expectation of the staff is to continue an assessment of the resident's status every shift for 72 hours.

The Director of Care stated the staff will record the assessment in the progress notes, which was not completed for the resident.

Failing to ensure that the resident was assessed at minimum every shift after the alleged physical abuse incident; put the resident at risk of an unidentified physical or emotional injury.

Sources: CIR, Resident's record, the Long-Term Care Investigation Package, Prevention of Abuse & Neglect of a Resident, Vii-G-10.00 (revised October 2022), Prevention of Abuse- Checklist for Investigating Alleged Abuse. VII-G-10.00(b), Interview with Director of Care.
[741831]

WRITTEN NOTIFICATION: Police notification
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service was immediately notified of the alleged abuse towards a resident.

Rationale and Summary

Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A Critical Incident Report was submitted to the Ministry of Long-Term Care regarding an allegation of staff to resident physical abuse. There was no record that the police services were contacted.
Director of Care confirmed the police were not called at the time of the reported incident.

Failing to ensure the appropriate police service was immediately notified when the resident reported alleged abuse, could have increased the risk of reoccurrence at the home.

Sources: CIR , Prevention of Abuse & Neglect of a Resident, VII-G-10.00 policy, interview with Director of Care.
[741831]

WRITTEN NOTIFICATION: Training
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

According to FLTCA, 2021, s.2(1) "staff", in relation to a long-term care home, means persons who work at the home,

(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

During the inspection, a record review of agency staff files was completed for RPN #107 and PSW #106. RPN #107 was employed in the Long-Term Care home from June 1 to December 19, 2022, and PSW #106 was employed in the home from August 29 to December 20, 2022.

The Long-Term Care home was not able to provide the inspector the orientation training records of PSW #106 and RPN #107.

The Executive Director (ED) indicated the agency staff complete training by their employer, but not on the home's specific policies. The ED stated that they are actively working on an onboarding training process to ensure that all the training and orientation requirements are fulfilled for agency staff.

The Director of Care (DOC) indicated all training requirements for the licensee's employees are

completed on an online system called Relias. The DOC confirmed the online orientation is completed prior to the staff working with the resident independently. They also confirmed that the agency staff did not receive the same online training as required by the licensee's employees.

Source: Record review of employee files, interviews with Executive Director and Director of Care.
[741831]

WRITTEN NOTIFICATION: Staff records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 278 (1) 3.

The licensee has failed to ensure that a record is kept for each staff member of the home, as required under subsection 81 (2) of the Act.

Rationale and Summary

According to FLTCA, 2021, s.2(1) "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

During the inspection, a record review of agency staff files was completed for RPN #107 and PSW #106.

RPN #107 was employed in the Long-Term Care home from June 1 to December 19, 2022. PSW #106 was employed in the home from August 29 to December 20, 2022.

The staff records did not contain both staff members' police record check.

The ED stated that the agency obtains and keep the police record check of the staff.

Failing to keep police checks onsite at the LTC home put residents at a potential risk of harm for abuse.

Sources: Record review of staff files, and Interviews with Team Experience Coordinator and Executive Director.
[741831]

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes
NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 356 (3) 1.

The licensee has failed to commence any alterations or renovations to the home without first receiving the approval of the Director.

Rationale and Summary

During the entrance conference with the Long-Term Care Home, the inspector was informed that air conditioning units were being installed in resident rooms.

On the second floor, the resident's worship room doors were closed and occupied by contractors. The Executive Director (ED) stated that the contractor has been working within the home since December 2022 and would be completing the project at the end of January 2023.

The worship room was occupied with the storage of isolation caddies and waste bins, a desk workspace, a health and safety board for the contractors, a mini fridge, microwave, and a variety of construction supplies. This resident home area was unusable by the residents and their loved ones within the Long-Term Care Home.

There was no submission to the Long-Term Care Capital Development Division for approval for the installation of air conditioning units and the use of resident space.

The licensee failed to submit a plan and receive approval of the Director prior to commencing any alterations to the home and use of resident space.

Source: Observations of resident home area. Record review of submission project plans and interview with Executive Director and contractor.
[741831]

WRITTEN NOTIFICATION: Infection prevention and control program
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (4) (c)

The licensee failed to ensure that the interdisciplinary infection prevention and control team meets at least quarterly.

Rationale and Summary

During an interview, the Infection Prevention and Control (IPAC) lead stated they became the permanent IPAC lead in November 2022. Prior to November, they were the acting IPAC lead.

The IPAC lead provided meeting minutes for an IPAC meeting in January 2023. They indicated this was the first formal IPAC meeting they had held. They stated that a quarterly Professional Advisory Committee (PAC) meeting that might have included the quarterly IPAC meeting was not held in December 2022 as scheduled.

By failing to hold quarterly IPAC meetings with the interdisciplinary team, there was a potential risk of lack of coordination and implementation of the program.

Sources: Interviews with IPAC lead, review of meeting minutes.
[571]

WRITTEN NOTIFICATION: Designated lead — housekeeping, laundry, maintenance
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

The licensee has failed to ensure that the designated lead for each of the housekeeping, laundry services and maintenance services programs, had a post-secondary degree or diploma.

Rationale and Summary

In an interview, the Director of Environmental Services (DES) confirmed they were the designated lead for housekeeping, laundry, and maintenance services.

The Executive Director (ED) indicated they were not involved in hiring the DES. The DES's employee file did not include a copy of any post-secondary degree or diploma.

Sources: Interviews with the ED and DES and review of DES employee file.
[571]

WRITTEN NOTIFICATION: Designated lead – Infection Prevention and Control
NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 2.

The licensee failed to ensure that the infection prevention and control (IPAC) lead works in that position on site at the home at least 26.25 hours per week.

Rationale and Summary

The infection prevention and control (IPAC) lead/Assistant Director of Care (ADOC) indicated that they did not track the hours (26.25) that they worked as the IPAC lead. They indicated they performed IPAC duties daily as well as performing other duties. They were unsure of the hours they spent in the IPAC lead role each week. In addition, there was no other person to fill the role when they were on vacation or off sick.

By failing to ensure the IPAC lead worked 26.25 hours per week on site in their position, the lead's ability to perform there IPAC responsibilities were impacted putting the residents at risk of infection.

Sources: interview with IPAC lead and review of the schedule.
[571]

COMPLIANCE ORDER CO #001 Infection prevention and control program
NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

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

Specifically, the licensee shall at minimum:

1) Educate all registered nursing staff, the Director of Care, associate Directors of Care, and the IPAC lead and their alternate on the "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units" version 9, dated January 18, 2023, specifically:

(a) subsection titled "Management of Symptomatic Individuals" pages 23-27; and,

(b) section two titled "COVID-19 Symptoms", pages 5-7, of "Management of Cases and Contacts of COVID-19 in Ontario", November 30, 2022 (Version 15.1) that is referred to in the "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units"

2) Keep a record of the education, date, names of attendees and proof of the education provided.

Grounds

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were complied with.

In accordance with the document "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units" version 8, dated October 6, 2022, in place at the time of this non-compliance, states that when a resident is symptomatic: residents must self-isolate and be placed on Additional Precautions, medically assessed, and tested. In addition, all symptomatic residents must be tested for COVID-19, even during non-COVID-19 outbreaks, using a laboratory-based molecular test (PCR) or a rapid molecular test (RAT). RATs have a significantly lower sensitivity for COVID-19 than molecular tests and should not be used routinely for residents of LTCHs and RHs. Results of RATs (positive or negative) should not change the management plan for a symptomatic resident (i.e., they still must isolate and be treated as a suspect case until their molecular test results are known).

In addition, page 23 of this document under the "signs and symptoms" link refers to "Management of Cases and Contacts of COVID-19 in Ontario", August 31, 2022 (Version 15.0), that was in place at the time of this inspection. Section two titled "COVID-19 Symptoms" pages 5-7, states one or more of the following most common symptoms of COVID-19 necessitate immediate COVID-19 testing and treatment if eligible: fever and/or chills; cough; shortness of breath; decrease or loss of smell or taste.

Rationale and Summary

The medical records for a resident indicated in a one- month period, the resident displayed six signs and symptoms of a specified illness. Two medications were administered more frequently to manage these symptoms. The resident was not placed on isolation precautions and continued to leave their room and attended meals in the main dining room.

After specified length of time, a resident was placed on isolation precautions and the home was declared in outbreak.

RPN #119 indicated that if a resident has signs or symptoms the resident would still be isolated.

The licensee failed to isolate the resident and respond appropriately when the resident displayed signs and symptoms of a specified illness, putting other residents at risk.

Sources: "COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other

Congregate Living Settings for Public Health Units" version 8, dated October 6, 2022, and "Management of Cases and Contacts of COVID-19 in Ontario", August 31, 2022 (Version 15.0), resident medical records, interview with RPN #119.
[571]

This order must be complied with by April 6, 2023

COMPLIANCE ORDER CO #002 Housekeeping
NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

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

Specifically, the licensee shall:

1. Develop and implement a plan to ensure high touch surfaces are cleaned at least twice daily during outbreak, including who is responsible for ensuring the high touch surfaces are cleaned and include a backup plan if they have not been cleaned at least twice daily. This must include weekends, holidays, and afterhours. Keep a written record of the plan to provide to MLTCH Inspectors upon request.

2. Develop and implement a method of documentation that indicates whether high touch surfaces were cleaned at least twice daily during an outbreak.

3. Educate all housekeeping staff, Infection Control Lead and their alternate, the Director of Environmental Services and any additional staff responsible for cleaning or ensuring cleaning of high touch surfaces during outbreak on the following:

(a) the sections of policy # XII-D-10.40 (b) "Housekeeping Cleaning Frequency Schedule - Outbreak", dated July 2020 (or most up to date version), pertaining to high touch surfaces.

(b) the plan implemented as ordered above.

(c) the method of documentation implemented as ordered above.

4. Keep a copy of the education, including, who provided the education, the date, and proof confirming the education was completed. Provide the records to the inspectors upon request.

Grounds

The licensee has failed to ensure high touch surfaces were cleaned twice daily during outbreak in accordance with evidence-based practices.

The Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings, dated July 16, 2021, directs that high touch or frequently touched surfaces are to be cleaned and disinfected at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Specifically, staff did not comply with policy # XII-D-10.40 (b) “Housekeeping Cleaning Frequency Schedule - Outbreak”, dated July 2020, which was included in the licensee’s housekeeping program.

Rationale and Summary

In an outbreak, the licensee’s updated housekeeping policy directs staff to clean high touch surfaces twice daily.

Housekeeper #120 stated they reviewed the updated policy but indicated they did not have time to clean the high touch surfaces twice per day during the outbreak.

Failure to clean and disinfect high touch surfaces including could contribute to the spread of infectious agents during outbreak.

Sources: CIR , “The Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental

Cleaning in Healthcare Settings", dated July 16, 2021, "Housekeeping Cleaning Frequency Schedule-Outbreak – XII-D-10.40(b)" and "Housekeeping Cleaning Frequency Schedule-XII-D-10.40(a)"- dated July 2020; interviews with Housekeepers #120 and the Director of Environmental services.
[571]

This order must be complied with by May 19, 2023

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.