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

Public Report

Report Issue Date: June 26, 2025

Inspection Number: 2025-1013-0003

Inspection Type:
Critical Incident
Follow up

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Case Manor Community, Bobcaygeon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 9, - 11, 13, 16, - 20, 23, 24, 2025
The inspection occurred offsite on the following date(s): June 19, 20, 2025

The following intake(s) were inspected:

- Intake: #00134707 -Follow-up #: 1 - CO #003 FLTCA, 2021 - s. 24 (1) - Duty to Protect - Compliance Due Date (CDD) March 28 2025
- Intake: #00134708 - Follow-up #: 1- CO #010 O. Reg. 246/22 - s. 24 (1) - Air Temperature - CDD April 30, 2025
- Intake: #00134710 - Follow-up #: 2 - CO #001 O. Reg. 246/22 - s. 24 (1) - Air Temperature - CDD September 2024, Re-inspection fee (RIF) $500.00
- Intake: #00142144 - Follow-up #: 1 - CO #002/2025_1013_0001 O. Reg. 246/22 - s. 58 (1) 1, CDD May 16, 2025
- Intake: #00142145 - Follow-up #: 1 - CO #001/2025_1013_0001, FLTCA, 2021 - s. 27 (1) (a) (ii) CDD May 16, 2025
- Intake: #00145366 - Follow-up #: 1 - CO #002 / 2025- 1013-0002 (A1), O. Reg. 246/22 - s. 58 (4) (c) , Responsive behaviours, CDD June 9, 2025
- Intake: #00145367 - Follow-up #: 1 - CO #001 / 2025-1013-0002, FLTCA, 2021 - s. 24 (1) Duty to Protect, CDD June 9, 2025

- Intake: #00148570 - Follow-up #: 2 - CO #004/2024-1013-0003, O. Reg. 246/22 - s. 57 (1) 4. - Pain Management - Monitoring of Resident's Response - CDD March 28 2025, RIF $500.00
- Intake: #00148572 -Follow-up #: 2 - CO #008 / 2024-1013-0002, FLTCA, 2021 - s. 6 (5) - involvement of resident, SDM, ect - CDD March 28, 2025, RIF $500.00
- Intake: #00142437 -regarding sexual abuse of a resident by a resident.
- Intake: #00144234 -regarding sexual abuse of a resident by a resident.
- Intake: #00143953 -regarding improper care of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2024-1013-0002 related to FLTCA, 2021, s. 24 (1)
Order #010 from Inspection #2024-1013-0002 related to O. Reg. 246/22, s. 24 (1)
Order #001 from Inspection #2024-1013-0001 related to O. Reg. 246/22, s. 24 (1)
Order #002 from Inspection #2025-1013-0001 related to O. Reg. 246/22, s. 58 (1) 1.
Order #001 from Inspection #2025-1013-0001 related to FLTCA, 2021, s. 27 (1) (a) (ii)
Order #002 from Inspection #2025-1013-0002 related to O. Reg. 246/22, s. 58 (4) (c)
Order #001 from Inspection #2025-1013-0002 related to FLTCA, 2021, s. 24 (1)
Order #004 from Inspection #2024-1013-0002 related to O. Reg. 246/22, s. 57 (1) 4.
Order #008 from Inspection #2024-1013-0002 related to FLTCA, 2021, s. 6 (5)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

Quality Improvement
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee failed to obtain the Director's approval before making alterations to the home.

The second-floor activity room was observed to be locked and inaccessible to residents. The space was being used for storage and contained a hydrocollator, creating potential safety concerns.

Upon notification, the Executive Director restored the room to its intended use as a resident space, in accordance with the approved floor plan.

Source: Observations.

Date Remedy Implemented: June 13, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 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 a resident's plan of care provided clear directions to staff related to oral care. Specifically, the plan of care for a resident did not include clear directions regarding the use and cleaning of an oral device. The resident's oral device was not removed at bedtime care on, causing the resident to choke during the night.

Sources: The resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: 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 the plan of care for a resident was documented. Specifically, a Personal Support Worker (PSW) inaccurately documented that the resident's care needs were provided. The home's investigation notes and interviews with the PSW and the ADOC indicated the resident did not receive care as per the residents plan of care. Additionally, the provision of oral care during the day shift two days prior.

Sources: The resident's clinical records, the home's investigation notes and Interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall 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.

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the licensee failed to use the checklist and investigation template to guide the investigation of an incident of neglect involving a resident. Furthermore, the licensee did not maintain a record of interviews conducted with the staff involved in the alleged incident of neglect.

Sources: The home's investigation notes, and licensee policies titled "Prevention of Abuse & Neglect of a Resident",

WRITTEN NOTIFICATION: Reports of investigation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)

Licensee must investigate, respond and act

s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). Specifically, the Director was not notified of the results of the investigation into an allegation of improper/incompetent treatment or care of a resident that resulted in

harm or risk to the resident.

Sources: Critical Incident Report and interview with staff.

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 a person who had reasonable grounds to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.
Staff witnessed a resident inappropriately touching a co-resident, and again on the following day. However, the alleged sexual abuse was not reported to the Director until two days after the first incident.

Sources: Critical Incident Report, residents clinical records, and staff interviews.

WRITTEN NOTIFICATION: Retraining

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.
The licensee has failed to ensure that a Registered Nurse (RN) received the

required annual retraining on the long-term care home's policy regarding zero tolerance for abuse and neglect of residents.

A Critical Incident Report was submitted to the Director concerning the alleged sexual abuse of a resident by a co-resident. The incidents occurred on two consecutive days. Two different RNs were present during the incidents but did not report the alleged abuse immediately, as required.

According to staff training records, one RN last received training on the home's zero tolerance policy in 2023. The next documented training was not completed until 2025, indicating a lapse in the required annual retraining.

Sources: Critical Incident Report and staff records.

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that each resident of the home was bathed using the method of their choice.

A review of records indicated that several residents did not receive a tub bath in accordance with their preferences due to a mechanical tub chair being out of service. The Maintenance Manager confirmed that while two tub chairs required repair, three tub chairs were operational, and available to be used. The Interim Director of Care indicated that there was no clear explanation from staff as to why the available spare tub chairs or equipment were not utilized to accommodate residents' bathing preferences.

Sources: Resident clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Oral care

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

Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

Oral care

s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,

(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee has failed to ensure that a resident received oral care in the morning and evening, including the cleaning of dentures. Specifically, two PSWs transferred the resident to bed and did not provide oral care or remove the resident's oral device.

Sources: A resident clinical records, Critical Incident Report, the home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

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 appropriate actions were taken to respond to the needs of a resident when the resident was exhibiting responsive behaviours. This includes the failure to conduct required assessments, implement interventions, and document the resident's responses to those interventions.

A Critical Incident Report was submitted to the Director regarding an incident in

which a resident inappropriately touched a co-resident. Following this incident, a referral was made to the Behavioural Support Team, indicating that a resident was exhibiting new or worsening behaviours. A Dementia Observation System was initiated the following day. However, there was no evidence of any additional assessments being completed, as required by the licensee's policy on Behavioural Support Teams.

Less than a month later, another Critical Incident Report was submitted to the Director, indicating that the same resident was involved in further incidents of alleged sexual abuse towards a different co-resident.

To date of the inspection, the referral for the resident remained incomplete. The incomplete assessment includes assessments of medications, MDS outcome scores to identify any changes from the previous assessment. any additional referrals that may be required, and a care plan review. The referral also includes a section that prompts the assessor to notify the Substitute Decision Maker (SDM), and to plan a date for a interdisciplinary team meeting.

The licensee's failure to ensure that appropriate actions were taken in response to the resident's demonstrated responsive behaviours placed co-residents at risk of continued exposure to abuse.

Sources: Critical Incident Report's, resident's clinical health records, licensee's policy Responsive Behaviours Management, and interview with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall,

1. Re- educate of the home's policy prevention of abuse and neglect with indicated Personal Support Workers.
2. Audit indicated Personal Support Workers documentation daily for one week to ensure accurate documentation of care provided to residents assigned to the PSWs.
3. The licensee shall review the policy Prevention of Abuse and Neglect with the leadership team at the LTCH who are responsible in completing the investigation into allegation of abuse and neglect. The review shall focus on the use of checklist and investigation templates identified in their policy.
4. A manger(s) will facilitate structured discussions (e.g., nursing huddles or interdisciplinary team meetings) to explore why staff are not promptly implementing interventions or alternative interventions when existing ones fail to prevent resident-to-resident incidents, including sexual abuse.
- Focus on identifying barriers such as lack of awareness, unclear protocols, communication gaps, or decision-making delays.
- Encourage open dialogue to uncover systemic or workflow issues.
- Document all feedback, including dates, discussion points, and names of participants.
- Provide this documentation to the Inspector(s) as evidence of the long-term care home's analysis.

5. Development and Implementation of a plan:
Based on the information gathered from the direct care staff in the nursing department, the licensee shall develop, implement, and document a plan to ensure staff are well equipped to immediately take actions to reduce risk or potential risk of resident-to-resident altercations.

Grounds

The licensee has failed to ensure that a resident was protected from neglect.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Critical Incident Report and clinical records for a resident revealed that, the resident was found gargling and struggling to breathe, unable to talk or cough. The resident's condition improved once a oral device was removed. Investigation notes and interviews with PSWs indicated they assisted the resident to bed but did not provide oral care or remove the resident's oral device during the evening shift.

The following non-compliances were also identified within this report, specific to the critical incident report submitted under improper/incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident:
FLTCA, 2021, s. 25 (1). Policy to promote zero tolerance.
O. Reg. 246/22, s. 38 (1) (a). Oral care.
FLTCA, 2021, s. 6 (9) 1. Documentation.
FLTCA, 2021, s. 6 (1) (c). Plan of care.
O. Reg. 246/22, s. 104 (2). Notification re incidents.
FLTCA, 2021, s. 27 (2). Reports of investigation

The failure to provide a resident with oral care, including the removal of oral devices, led to actual harm when the resident choked during the night. Additionally, the licensee did not follow their own policy during the investigation of the incident, did not ensure PSW staff accurately documented the care provided, did not ensure the care plan gave clear directions regarding oral care, and failed to notify the SDM or report the investigation results to the Director.

Sources: Critical Incident Report, the resident's clinical records, interviews with staff.

The licensee failed to protect a resident from abuse by a resident.

A Critical Incident Report was submitted to the Director, reporting alleged sexual abuse of a resident by a resident.

Staff reported witnessing a resident inappropriately touching a co- resident. At the time of the incident, the resident was on 15-minute safety checks due to previous incidents of inappropriate touching involving another co-resident. This intervention proved ineffective, yet no additional measures were implemented to safeguard co-residents. The following day, another incident of inappropriate touching involving the resident and co-resident occurred. There was no indication that immediate actions or interventions were taken to protect co -resident again at this time.
The following day, the licensee became aware of the incidents, initiated 1:1 supervision for the resident, and began an internal investigation.

During the investigation, co -resident appeared tearful and disclosed to the interviewer that they had been inappropriately touched on multiple occasions.

By failing to take immediate action to protect co resident, the licensee placed the resident at risk of repeated sexual abuse and failed to ensure timely emotional, physical, and psychological support the resident required.

Sources: Critical Incident Report, licensee’s internal investigation, clinical records of residents, and staff interviews.

This order must be complied with by August 29, 2025

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

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

2025-1013-0002- Compliance Order FLTCA, 2021 s. 24 (1)
2025-1013-0001- Written Notification FLTCA, 2021 s. 24 (1)
2024-1013-0002 - Compliance Order High Priority FLTCA, 2021 s. 24 (1)
2023-1013-0002 - Written Notification FLTCA, 2021 s. 24 (1)
2022-1013-0001 - Written Notification FLTCA, 2021 s. 24 (1)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

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

COMPLIANCE ORDER CO #002 Notification re incidents

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

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 a plan to ensure resident and the substitute decision makers are notified of the outcome of the internal investigation of abuse and neglect.

Ensure the documentation of plan and how it was implemented is available for the inspector upon request.

Grounds

1. The licensee failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation immediately upon its completion.

A Critical Incident Report (CIR) was submitted to the Director, indicating that a resident inappropriately touched a co-resident.
There was no documentation or indication that resident's substitute decision-maker was informed of the founded results of the internal investigation.

By failing to notify the resident and substitute decision maker, this resulted in a lack of transparency and accountability, and diminished trust in the care provider. This could lead to emotional distress for the resident and SDM and hinder informed decision-making.

Sources: Critical Incident Report, a resident's clinical health records, and staff interviews.

2. The licensee failed to ensure that the resident's substitute decision-maker was notified of the results of the investigation immediately upon its completion.

A Critical Incident Report was submitted to the Director, indicating that a resident inappropriately touched a co-resident.
There was no documentation or indication that the co-resident's substitute decision-maker was informed of the founded results of the internal investigation.

By failing to notify the resident and substitute decision maker, this resulted in a lack of transparency and accountability, and diminished trust in the care provider. This could lead to emotional distress for the resident and SDM and hinder informed decision-making.

Sources: Critical Incident Report, a resident's clinical health records, and staff interviews.

3. The licensee has failed to ensure that the substitute decision-maker (SDM) was

notified of the results of an alleged neglect investigation. Specifically, the SDM for a resident was not notified of the results of the alleged neglect investigation.

By failing to notify the resident and substitute decision maker, this resulted in a lack of transparency and accountability, and diminished trust in the care provider. This could lead to emotional distress for the resident and SDM and hinder informed decision-making.

Sources: Critical Incident Report, a resident's progress notes, interviews with the interim DOC.

This order must be complied with by August 29, 2025

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake: #00148570 - Follow-up #: 2 -CO #004/2024-1013-0003, O. Reg. 246/22 - s. 57 (1) 4. - Pain Management - Monitoring of Resident's Response - CDD March 28 2025 Intake: #00148572 -Follow-up #: 2 -CO #008 / 2024-1013-0002, FLTCA, 2021 - s. 6 (5) - involvement of resident, SDM, ect - CDD March 28, 2025 Intake: #00134710 - Follow-up #: 2 - O. Reg. 246/22 - s. 24 (1) - Air Temperature - CDD September 2024. [IR 2024 1013 0001]

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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

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.