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

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

Original Public Report

Report Issue Date: November 25, 2024
Inspection Number: 2024-1193-0004
Inspection Type: Complaint Critical Incident
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Orchard Villa, Pickering

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2024 and November 1, 4, 5, 7, 8, 2024

The following intake(s) were inspected:

- Intake related to a complainant regarding multiple resident care concerns
- Intake related to a complaint regarding multiple resident care concerns
- Intakes related to an alleged resident to resident abuse incident
- Intakes related to an alleged staff to resident abuse incident
- Intake related to an incident regarding a missing resident
- Intakes related to resident falls resulting in injury

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

1. The licensee has failed to ensure that a resident was free from financial abuse from a staff member.

Rationale and Summary

A Critical Incident (CI) report submitted to the Director indicated that a family member had observed video footage in a resident's room, where a staff member entered the room and immediately proceeded to their bedside table where the resident stored cigarettes. The resident stated they purchased a video camera when they noted missing cigarettes over a period of two months and wanted to know who was taking their cigarettes.

The Director of Care (DOC) stated to the Inspector that the resident provided video footage taken that revealed the staff member entering the resident's room and

immediately proceeded to the resident's bedside table.

DOC acknowledged that the actions of the staff member towards the resident constituted abuse. DOC confirmed the staff member's employment was terminated and was no longer employed in the home to be interviewed.

Failure to protect the resident from abuse put them at risk of further financial abuse and could have negatively impacted the resident's quality of life and emotional wellbeing.

Sources: CI report, home's investigation notes, video footage, resident records, staff file, interviews with resident and DOC.

2. The licensee has failed to ensure that a resident was free from physical abuse from personal support worker (PSW) #120.

Rationale and Summary

A CI report submitted to the Director indicated that PSW #115 had witnessed PSW #120 slap a resident on their right shoulder during personal care. There was no injury to the resident. PSW #115 stated they were told by other staff of other incidents with PSW #120, with no specific dates and that the resident would only become agitated with PSW #120.

The home's investigation into the alleged physical abuse incident indicated several staff were interviewed, PSW #122, PSW #115 and Registered Practical Nurse (RPN) #123 who had stated they were aware PSW #120 would slap the resident during care. PSW #120 had denied the allegations of abuse when interviewed.

The DOC acknowledged that the actions of PSW #120 towards the resident constituted abuse. The DOC confirmed PSW #120's employment was terminated

and was no longer employed in the home to be interviewed.

Failure to protect the resident from abuse put them at risk of further abuse and could have negatively impacted the resident's quality of life and emotional wellbeing.

Sources: CI report, home's investigation notes, resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 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.

1. The licensee has failed to immediately report to the Director an incident of financial abuse to a resident.

Rationale and Summary

A CI report submitted to the Director indicated that a family member had observed video footage in a resident's room where a staff member entered the resident's room and immediately proceeded to their bedside table where the resident stored cigarettes. The resident stated they purchased a video camera when they noted

missing cigarettes over a period of two months and wanted to know who was taking their cigarettes.

DOC confirmed a CI report was not submitted related to the financial abuse incident on the date they were notified, and had not reported the incident until two days later. The DOC acknowledged that the staff member's actions constituted financial abuse and should have been reported to the Director immediately.

Failure to submit reports of alleged abuse posed a risk to the residents of the home as this may lead to unreported incidents of abuse.

Sources: CI report, home's investigation notes, video footage, resident's records, staff file, interviews with resident and DOC.

2. The licensee has failed to immediately report to the Director an incident of physical abuse to a resident.

Rationale and Summary

A CI report submitted to the Director indicated that PSW #115 had witnessed PSW #120 slap a resident on their right shoulder during care. There was no injury to the resident. Review of the resident's clinical records indicated they required two staff during care. PSW #115 stated they were told by other staff of other incidents during care to the resident with no specific dates and that the resident would only become agitated during care with PSW #120.

The home's Zero Tolerance of Resident Abuse and Neglect Program policy indicated slapping is physical abuse and the home's Zero Tolerance of Resident Abuse and Neglect policy indicated under Reporting
1. Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the

Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

The DOC acknowledged that the actions of PSW #120 towards the resident constituted abuse. The DOC confirmed that staff were aware of incidents of physical abuse to the resident and did not immediately report them to their supervisor or management. DOC confirmed PSW #120's employment was terminated and was no longer employed in the home to be interviewed.

Failure of staff to submit reports of alleged abuse posed a risk to the residents of the home as this may lead to unreported incidents of abuse.

Sources: CI report, home's investigation notes, resident's records, staff file, interviews with PSW staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that when a resident suffered a fall, the use of a falls prevention measure should have been applied.

Rationale and Summary

A CI report was submitted to the Director regarding the fall of a resident resulting in injury and subsequent transfer to hospital.

Review of the resident's clinical records indicated that the resident was to have a falls prevention measure in place at the time of their fall. Progress notes from the day of the fall and the home's investigation notes indicated the falls prevention measure was not on the resident at the time of the fall.

During an observation of the resident, the falls prevention measure was noted to not be on the resident. PSW #111 confirmed the falls prevention measure was not in place at the time of the observation.

Interview with the DOC and RPN #102 confirmed that the resident should have had the falls prevention measure in place as per their falls interventions in the plan of care.

Failure to follow the falls interventions in the plan of care placed the resident at risk for injury.

Sources: CI report, home's investigation notes, observation, resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 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 a resident with altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A CI report was submitted to the Director regarding the fall of a resident resulting in a wound and subsequent transfer to hospital.

The resident's clinical records indicated an initial skin and wound assessment was completed on the day of the resident's fall and upon return from hospital. Documentation indicated the resident had returned from hospital with a wound. No weekly skin and wound assessment had been completed for the wound after return from hospital.

DOC and RPN #102 confirmed a weekly skin and wound assessment should have been completed for the wound until the wound had healed.

Failing to complete weekly skin assessments to the resident's wound increased the risk of delay in treatment if it were to deteriorate.

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

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are

developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee failed to ensure that the following are developed to meet the needs of resident #007 with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Rationale and Summary

A CI report was submitted to the director related to an altercation between residents #007 and #009. Resident #007 entered resident #009's personal space while resident #009 was seated. Resident #009 then kicked resident #007 which resulted in a fall and significant injuries.

There was no care planned strategies prior to the incident, to indicate that resident #009 would exhibit responsive behaviors when others would enter their personal space.

Interview with PSW #127 indicated that the resident was known to have responsive behaviors and confirmed that resident #007 was in resident #009's personal space when the altercation occurred. PSW #127 further indicated that resident #007 did not like others in their personal space. Interview with the DOC and Behavioural Support of Ontario (BSO) RPN #124 indicated that this information should be in resident #007's care plan to communicate their triggers and interventions.

Failure to have written strategies for resident #007's known trigger did not minimize the potential for altercations.

Sources: CI report, resident #007 and #009's clinical records, observations, and

interviews with staff and management.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee failed to implement Additional Requirement 6.1 of the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, Revised September 2023" (IPAC Standard), when PPE was not made available and accessible to staff appropriate to their level of risk related to additional contact precautions.

Rationale and Summary

During an IPAC tour, two residents were noted to be on contact precautions. Outside the residents' doors were hanging caddies where Personal Protective Equipment (PPE) supplies were to be stocked. There were no gloves available at point of care where the PPE should have been readily accessible.

The IPAC Lead confirmed staff were to wear the appropriate PPE prior to going into a resident's room on additional precautions. They verified that gloves should have

been available and accessible at point of care.

There was an increased risk of transmission of communicable disease when not all the required PPE was available at point of care.

Sources: Observations and interview with IPAC Lead.

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. 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. O. Reg. 246/22, s. 105, 390 (2).

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

Rationale and Summary

A CI report was submitted to the Director regarding an incident of alleged abuse involving a resident. Review of the resident's clinical records indicated the resident's substitute decision maker (SDM) alleged physical abuse by RPN #108 while performing care on the resident. Registered Nurse (RN) #110 stated they had not notified the police when they became aware of the alleged physical abuse. There was no record that the police services were contacted.

DOC acknowledged that the police were not called when they became aware of the alleged physical abuse incident.

Failure to ensure the appropriate police service was notified upon alleged abuse, could potentially increase the risk of recurrence at the home.

Sources: CI report, resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber when a resident received medication not prescribed to be administered at a specific time.

Rationale and Summary

A CI report related to a medication incident was submitted to the Director. Specific medications were prescribed by the physician. A resident was administered the incorrect medication that could have affected their health status.

RPN #108 stated the medication that should have been administered to the resident during the day shift was unopened at the beginning of their evening shift. The home's investigation notes indicated in an interview with RPN #119 who had stated that they had administered the incorrect medication to the resident.

The DOC confirmed RPN #119 had administered medication that was not ordered in

accordance with directions for use specified by the prescriber. RPN #119 was no longer employed in the home to be interviewed.

The home's failure to ensure that a resident received medication as directed by the prescriber may have led to a potential impact to the resident's health status.

Sources: CI report, review of resident's clinical records, electronic medication administration record (eMAR), interviews with staff.

WRITTEN NOTIFICATION: HIRING STAFF, ACCEPTING VOLUNTEERS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (3)
Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The licensee has failed to ensure that RPN #123 had a vulnerable sector check prior to their hire.

Rationale and Summary

A CI report submitted to the Director indicated that PSW #115 had witnessed PSW #120 slap a resident on their right shoulder during care. There was no injury to the resident. RPN #123 was involved in the incident. During the inspection, Inspector requested a copy of RPN #123's police vulnerable sector check record (VSC). The Senior Executive Director (SED) #116 and DOC stated that the home completed

these VSC's prior to hire and that they were unable to locate one for RPN #123.

There was a risk to the residents' safety when the home did not ensure RPN #123 had completed a vulnerable sector check prior to their hire as required.

Sources: Employee records, interview with SED and DOC.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

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

1) The DOC or management designate shall provide education to all staff that provide care to resident #006 on the criteria to initiate a Dementia Observation System (DOS), and how to complete the DOS in its entirety.
2) The DOC or management designate shall develop and implement a process to verify that the DOS tool is completed in its entirety, when initiated. The DOC or management designate shall complete one audit, one time a week for four weeks, of a resident on the Behavioural Support Unit (BSU) that requires a DOS. The audit shall include the name of the person completing the audit, the date, the name of the resident audited, and identify whether the DOS was completed in its entirety. The audit shall indicate what corrective measures were implemented if the DOS is

incomplete.
3) All audits and training records shall be documented, retained, and made available to Inspectors, immediately upon request.

Grounds

The licensee failed to ensure that resident #006 was monitored.

Rationale and Summary

A CI report was submitted to the Director after resident #006 was reported missing. Resident #006 was found by police and taken to the hospital where it was confirmed they had sustained injuries.

Resident #006's clinical records were reviewed and indicated that the resident had several documented attempts to elope prior to this incident. During the course of the inspection, progress notes indicated that resident #006 continued to elope.

Interventions to keep resident #006 safe included monitoring every 30 minutes using the Dementia Observation System (DOS). The DOS was reviewed and there were several missing entries. PSW #127, RPN #129, and RN Supervisor #126 indicated that the DOS was the primary method of monitoring the resident and that the BSO team would then analyze and trend the information to create interventions. RPN #129 further indicated that the resident exhibited increased risk to elope while passing through the lobby and seeing main exit of the building. RPN #129 indicated that this information was not captured through the DOS and thus not included in the resident's care plan.

The DOC and BSO RPN #124 indicated that the PSW assigned to resident #006 was expected to complete the DOS in its entirety and that failure to do so could result in an inaccurate analysis of behavioral trends and identification of

interventions.

Failure to complete the DOS did not promote the identification of interventions specific to resident #006.

Sources: CI report, Resident #006's clinical records, interviews with staff and management.

This order must be complied with by January 7, 2025

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

1) The DOC, Social Worker, and Medical Doctor, shall meet with the BSO RPN, and frontline staff to collaboratively develop and implement interventions to keep resident #006 from eloping. This shall be documented in their plan of care.

2) The identified interventions must be reassessed and evaluated for its effectiveness by the Director of Care or designate, the BSO RPN and a member of the frontline staff providing care to resident #006 on a weekly basis. If interventions are ineffective and the resident continues to elope, the DOC, Social Worker, and Medical Doctor, shall meet with the BSO RPN, and frontline staff to collaboratively develop and implement new interventions until interventions are effective. The reassessment and evaluation must be documented in the residents plan of care.
3) The BSO lead shall revise #006's care plan to include walking to and from the resident home area to the dining room as an identified trigger for elopement.
4) The BSO lead or designate shall provide education to all direct care staff working with resident #006 on the identified strategies including increased monitoring of resident #006 before and after mealtimes.
5) All records shall be documented, retained, and made available to Inspectors, immediately upon request.

Grounds

The licensee failed to ensure that the
(a) behavioural triggers for resident #006 were identified

Rationale and Summary

A CI report was submitted to the Director after resident #006 was reported missing. Resident #006 was found by police and taken to the hospital where it was confirmed they had sustained injuries.

Resident #006's clinical records were reviewed and indicated that the resident had several documented attempts to elope prior to this incident. During the inspection, progress notes indicated that the resident continued to elope. Interventions to keep resident #006 safe included monitoring every 30 minutes.

Interviews with RPN #129 indicated that the dining room for the resident home area faces the main entrance of the building. RPN #129 further indicated that resident #006 required increased supervision and redirection before and after meals since they would attempt to elope after seeing the main entrance doors when exiting or entering the dining room. RPN #129 confirmed that this known trigger was not documented in the resident's care plan. PSW #130, BSO RPN #124 and the DOC were unaware of this behavioral trigger for resident #006. BSO RPN #124 and the DOC indicated that this known trigger should have been documented in the residents care plan in order for it to be communicated to the staff responsible for monitoring resident #006.

Failure to identify the known behavioral triggers in the resident's care plan did not promote the safety and well being of resident #006.

Sources: CI report, resident #006's clinical records, interviews with staff and management.

The licensee failed to ensure that:
(b) strategies were developed and implemented to respond to resident #006's behaviours, where possible;

Rationale and Summary

A CI report was submitted to the Director after resident #006 was reported missing. Resident #006 was found by police and taken to the hospital where it was confirmed they had sustained injuries.

Resident #006's clinical records were reviewed and indicated that the resident had several documented attempts to elope prior to this incident. During the inspection, progress notes indicated that the resident continued to elope. Progress notes written by the BSO RPN #129 recommended a one to one (1:1) staff to monitor

resident #006. Care planned interventions to keep resident #006 safe included monitoring every 30 minutes.

RPN #129 and PSW #130 indicated that there were several incidences where the resident eloped and that the interventions were ineffective the day the resident was reported missing. RPN #129 and PSW #130 further indicated that when the resident was reported missing, no PSW was assigned to monitor the resident every 30 minutes due to decreased staffing. RPN #129 indicated that the most effective intervention for the resident was a 1:1 staff which was recommended by BSO but never implemented. BSO RPN #124 confirmed that resident #006 had several documented elopements and that the recommendation for 1:1 staffing was communicated to the DOC but never implemented.

The DOC indicated that when a 1:1 is recommended, it is implemented immediately and could not indicate why BSO's recommendation for 1:1 staffing was never implemented. Additionally, interviews with RPN #129 indicated that the dining room for the resident home area faces the main entrance of the building. RPN #129 further indicated that resident #006 required increased supervision and redirection before and after meals since they would attempt to elope after seeing the main entrance doors when exiting or entering the dining room. RPN #129 confirmed that this known trigger was not documented in the resident's care plan. PSW #130, BSO RPN #124 and the DOC were unaware of this behavioral trigger for resident #006. BSO RPN #124 and the DOC indicated that this known trigger should have been documented in the residents care plan in order for it to be communicated to the staff responsible for monitoring resident #006.

Thus, strategies for increased monitoring of resident #006 were not developed and implemented which did not promote the safety and well being of resident #006.

Sources: CI report, resident #006's clinical records, interviews with staff and management.

The licensee failed to ensure that:
(c) actions were taken to respond to the needs of resident #006, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Rationale and Summary

A CI report was submitted to the Director after resident #006 was reported missing. Resident #006 was found by police and taken to the hospital where it was confirmed they had sustained injuries.

Resident #006's clinical records were reviewed and indicated that the resident had several documented attempts to elope prior to this incident. During the inspection, progress notes indicated that the resident continued to elope. Progress notes were reviewed and indicated that a wander guard was trialed but never successfully implemented due to the resident's responsive behaviors. There was no documentation in the resident's clinical record to indicate that this intervention was reassessed.

RPN #129, RN Supervisor #126 and the BSO RPN #124 indicated that the wander guard should have been revisited with the responses to the intervention documented. Additionally, RPN #129 indicated that the resident had previously resided on a resident home area which required a code to enter and exit. The current home area resident #006 resides on requires them to go to the dining room, which is parallel to the lobby and main exit/entrance area. Thus, mealtimes were identified by RPN #129 as a trigger. Clinical records were reviewed, and there was no assessment to determine the suitability of the resident's current resident home area. RPN #129 indicated that because of this known trigger, the resident would be better suited on a different resident home area.

Sources: CI report, resident #006's clinical records, interviews with staff and management.

This order must be complied with by January 7, 2025

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.