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

North District
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Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: July 7, 2025
Inspection Number: 2025-1424-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Foyer Hearst - Mattice - Soins De Sante
Long Term Care Home and City: Foyer Des Pionniers, Hearst

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 18, 19, 2025
The inspection occurred offsite on the following date(s): June 23, 24, 25, 26, 2025

The following intake(s) were inspected:

- Intake: #00149705 - Proactive Compliance Inspection

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that when a resident was reassessed, that their plan of care was reviewed and revised when a resident's care needs changed regarding the resident's texture modified diet for both meals and snacks.

On a specific day in 2025, the Registered Dietitian reviewed a resident's plan of care for texture modified diet interventions, that were not added to the resident's plan of care.

Sources: A resident lunch meal observation; interviews with the resident, several staff and the resident's health records.

WRITTEN NOTIFICATION: Advice

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family

Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure to seek advice of the Residents' Council (RC) and the Family Council (FC), in carrying out the survey and in acting on its results.

The satisfaction survey was sent to residents and families in October 2024 without seeking advice from the RC and the FC. The President of the FC indicated that they did not provide advice or suggestions on acting on the results.

Sources: Satisfaction Survey, RC and FC minutes and interviews with the President of Family Council, the Executive Director and the Administrative Assistant.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (a)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);

The licensee has failed to ensure that the results of the survey were made available to the Residents' Council (RC) to seek their advice.

Interviews with the Executive Director (ED) who indicated that the results of the survey were documented but were not made available to the RC. The Assistant of the RC indicated that the results were not made available to the RC.

Sources: Interviews with the ED and the Assistant of the RC.

WRITTEN NOTIFICATION: Duty to respond

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

There were no separate Residents Council (RC) minutes available as they were integrated in the Family Council minutes. There was no documented record that a written response was provided to the RC within 10 days.

Sources: RC minutes and interview with the Executive Director (ED).

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors to non-residential areas were kept

closed and locked when they were unsupervised by staff. On a specific day in 2025, doors to tub rooms, shower rooms, a clean utility room, a meeting room, and a filing room were observed to be open and unsupervised by staff.

Sources: Observations on the A, B, and C wing home areas.

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (c)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(c) allows calls to be cancelled only at the point of activation;

The licensee has failed to ensure that the resident-staff communication and response system only allows calls to be canceled at the point of activation.

A Personal Support Worker (PSW) identified that the resident calls through the communication and response system are, at times, cancelled at the nursing desk because the personal staff response buttons do not turn off the call at the point of activation. A Registered Nurse (RN) confirmed that this occurred in the home and stated that when this occurs PSW staff members are supposed to inform a registered staff member who will cancel the call. However, they identified that the computer on the A wing of the home did not have a password and some PSW staff would turn off the resident call themselves at the nursing desk.

Sources: Observation, interviews with a PSW and an RN.

WRITTEN NOTIFICATION: Cooling requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (1)
Cooling requirements
s. 23 (1) Every licensee of a long-term care home shall ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices. O. Reg. 246/22, s. 23 (1).

The licensee has failed to ensure that a written heat related illness prevention and management plan for the home that meets the needs of the residents was developed in accordance with evidence-based practices.

A memo " Plan de prévention de maladies reliées à la chaleur/Heat related illness prevention plan" dated July 2, 2024 was reviewed. It was noted that the memo did not:
- identify specific risk factors that may lead to heat related illness and require staff to regularly monitor whether residents are exposed to such risk factors and take appropriate actions in response;
- identify symptoms of heat related illness and require staff to regularly monitor whether residents exhibit those symptoms and take appropriate actions in response;
- identify specific interventions that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness and to prevent or mitigate the identified symptoms of such an illness in residents;

Sources: Memo dated July 2, 2024 and interview with DOC.

WRITTEN NOTIFICATION: Air temperature

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

Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that temperatures were measured and documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

On a specific day in 2025, the Temperature Log dated June 2025 was reviewed. It was noted that the temperatures were not taken at least three time a day on several days and no temperatures were documented for six days.

Sources: Temperatures Log dated June 2025.

WRITTEN NOTIFICATION: Plan of care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 15.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions.

The licensee has failed to ensure that the requirements of a plan of care must be based on, at a minimum, an interdisciplinary assessment with respect to a resident's skin condition.

A resident had an altered skin integrity that was not documented in their plan of care. There was no wound goals, multidisciplinary interventions or strategies in

place for their skin conditions. The resident altered skin integrity had deteriorated since a specific month in 2025.

Sources: A resident observation and their health care record and interviews with registered nursing staff.

WRITTEN NOTIFICATION: General requirements

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

1) The licensee has failed to ensure that their interdisciplinary pain management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Director of Care (DOC) provided their updated policy and procedure on pain management. There was no record of the pain management program that was evaluated and updated at least annually. The DOC indicated that there was no annual evaluation of the pain management program.

Sources: Interview with the DOC and the Pain Management Policy.

2) The licensee has failed to ensure that their interdisciplinary skin and wound care

program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The DOC provided their policy and procedure for their skin and wound care program dated April 16, 2014. They had a revision of pressure injuries completed in October 2024, however no other review of other types of skin injuries required for their annual review under this program.

Sources: Interview with the DOC; review of their documentation of their skin and wound program titled "Skin Care: General guidelines" last revised as per page 2 of this document as April 16, 2014, and their RNAO gap analysis for pressure injuries dated October 2024.

WRITTEN NOTIFICATION: Housekeeping

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that high contact surfaces in resident bedrooms and bathrooms were disinfected at least daily with a low level disinfectant.

In accordance with O. Reg. s. 93. (2) (b) (iii), the licensee shall have an organized

program of housekeeping with procedures developed and implemented for disinfecting contact surfaces in accordance with evidence-based practices. The Public Health Ontario document 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in Health Care Settings' indicated that high contact surfaces require cleaning and disinfection at least daily.

The licensee's housekeeping policy identified that high contact surfaces in resident bedrooms and bathrooms were disinfected every second day. A Housekeeper confirmed this is the housekeeping routine that has been followed.

Sources: Cleaning and Disinfection Policy (HUM-INF-PRO, revised July 2024), interviews with a Housekeeper and the Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 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).

1) The licensee has failed to ensure that a section of a standard issued by the Director was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard, section 9.1 b, identifies that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene.

On a specific date in 2025, several PSWs staff provided mobility, transfers, feeding and meal assistance during the lunch meal without performing hand hygiene between residents or their environments.

Sources: Observations of the lunch meal in dining rooms A and B; interviews with several PSW 's and the IPAC Lead.

2) The licensee has failed to ensure that a section of a standard issued by the Director was complied with.

Specifically, the Infection Prevention and Control (IPAC) Standard, section 4.3, identifies that following the resolution of an outbreak, the IPAC team shall conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of these findings is to be created that makes recommendations to the licensee for improvements to outbreak management practices.

An enteric outbreak occurred in April 2025 where 23 residents were identified to experience symptoms. Following the resolution of the outbreak, a debrief session was not held to assess IPAC practices and provide recommendations for improvements to outbreak management practices.

Sources: Health and Safety committee meeting minutes, outbreak line listing, interviews with the IPAC Lead and the Director of Care (DOC).

WRITTEN NOTIFICATION: Medication management system

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the written policies related to the administration of drug was implemented.

The "Administration of Drugs Policy, Code 05-02-03, revised March 2023", was reviewed and requires under "Note: if the administered medication is a narcotic or controlled drug, signs narcotic Control Form in addition to the E-MAR".

During the medication administration observation, it was observed that a Registered Practical Nurse (RPN), had pre-poured the controlled substance for a resident earlier that morning. The RPN indicated that they were aware that it was not the policy and that they should have signed off the controlled substance only when administering the medication.

Sources; observation of the medication administration and policy "Administration of Drugs".

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that any controlled substance that is to be destroyed and disposed of, shall be separated from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Interviews with a Registered Nurse (RN) and a Registered Practical Nurse (RPN), they indicated that controlled substances that were to be destroyed and disposed off, were kept in the narcotic box in the medication cart. Both of the medication carts had narcotic boxes with controlled substances available for administration to residents, which also included a plastic separator called "Destroy", to put the destroyed controlled medications at the back of the same narcotic box.

Sources; Observation of the medication cart and the interviews with an RN and an RPN.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing

staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the Medical Director, the Registered Dietitian(RD), a qualified Personal Support Worker (PSW), one member of the Resident's Council (RC) and one member of the Family Council (FC) were members of the Continuous Quality Improvement (CQI) committee.

The CQI minutes were reviewed and it was noted that the above members were not members of the CQI committee. Discussion held with Executive Director (ED), who indicated that the above members were not members of the CQI committee.

Sources; CQI minutes and interview with the ED.

WRITTEN NOTIFICATION: Orientation

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(a) hand hygiene;
(b) modes of infection transmission;
(c) signs and symptoms of infectious diseases;
(d) respiratory etiquette;
(e) what to do if experiencing symptoms of infectious disease;
(f) cleaning and disinfection practices;

(g) use of personal protective equipment including appropriate donning and doffing; and
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee has failed to ensure that the orientation training for Infection Prevention and Control, as required under FLTCA s. 82 (2) 9., included all subjects required. The orientation training did not include section (f) regarding cleaning and disinfection practices or section (h) regarding handling and disposing of biological waste.

Sources: Orientation document, interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that a recommendation from the Chief Medical Officer of Health was followed.

Specifically, the 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings' document, effective February 2025, identified the recommendation that an Infection Prevention and Control (IPAC) audit was to be completed weekly for the duration of an outbreak.

The licensee experienced an enteric outbreak in April 2025 and the IPAC self-assessment audit was not completed weekly during this time.

Sources: Public Health Ontario IPAC self-assessment audit, interviews with the IPAC Lead and the Director of Care (DOC).

COMPLIANCE ORDER CO #001 Training

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 82 (4) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

A) Develop training materials on the Resident's Bill of Rights that can be used for annual training of all staff;

B) Develop training materials of prevention of abuse and neglect of residents, including the licensee's Prevention of Abuse and neglect policy, that can be used for annual training of all staff;

C) Develop training materials on the required sections of Infection Prevention and Control included in O. Reg. 246/22 s. 259 (2) that can be used for annual training of all staff.

D) Develop a schedule for providing training on sections (A), (B), and (C) to all staff

in the home.

E) A written record shall be kept of all training materials, schedule, and training provided.

Please submit the written plan for achieving compliance for inspection #2025-1424-0002 to a specified LTC Homes Inspector, MLTC, by email to northdistrict.mltc@ontario.ca by August 7, 2025.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

1) The licensee has failed to ensure that the retraining of the Residents' Bill of Rights and their policy to promote zero tolerance of abuse and neglect of residents were completed.

As specified in FLTCA 2021 s. 82 (2) 1, staff members shall receive training in the Residents' Bill of Rights, FLTCA 2021 s. 82 (2) 3, staff members shall receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and as specified in O. Reg. 246/22 s. 260 (1) this training shall be completed annually.

The Administrator indicated staff had not had annual retraining regarding the Residents' Bill of Rights or their annually revised policy to promote zero tolerance of abuse and neglect of residents in 2024 to date.

Sources: Interviews with several staff and the review of their #33 policy to promote zero tolerance of abuse and neglect of residents.

2) The licensee has failed to ensure that retraining on Infection Prevention and Control (IPAC) practices were completed.

As specified in FLTCA 2021 s. 82 (2) 9, staff members shall receive training in IPAC, and as specified in O. Reg. 246/22 s. 260 (1) this training shall be completed annually.

The IPAC Lead identified that there was not an organized program to provide annual retraining on IPAC to all staff members at this time.

Sources: Interview with the IPAC lead.

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #002 Communication and response system

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

A) Complete a review of the Resident-Staff Communication and Response System (RSCRS) to ensure the system can be easily seen, accessed and used by residents, staff and visitors at all times. Specifically, ensure all residents have a functional RSCRS device with which to make a call for assistance, and all staff have a functional RSCRS device that can cancel the call at the point of activation.

B) Ensure that calls for assistance from the RSCRS can be canceled only at the point of activation.

C) Complete a weekly audit of the RSCRS, including resident call buttons and staff RSCRS fobs. The audit shall include manually testing the resident personal RSCRS buttons to ensure they are functioning and sending a call for assistance, and manually testing the staff RSCRS fobs to ensure they are able to cancel a RSCRS call at the point of activation. The audits shall be completed for at least six weeks.

D) During the course of completing audits, if resident or staff RSCRS buttons and fobs are found not functioning as required, immediate corrective actions shall be taken.

E) A written record will be kept of everything required under sections (A), (B), (C), and (D).

Grounds

The licensee has failed to ensure that the resident-staff communication and response system (RSCRS) was easily used by staff and residents.

Upon observation of the RSCRS on two specified dates, two residents personal call buttons were not functioning properly and could not call for assistance. Further, a Personal Support Worker (PSW) could not cancel a resident's bathroom call when it had been rung. Additional staff members, including another PSW and an Registered Nurse (RN) identified that resident calls are sometimes cancelled at a computer at the nursing desk, and not at the point of activation, because the staff response buttons did not function properly and could not cancel the call.

An Administrative Assistant and the Administrator identified that only registered

staff should have access to the computer to cancel resident calls, however the computer on one of the wings of the home was not password protected and all staff had access to it. An RN confirmed that staff are supposed to inform registered staff when a call cannot be cancelled at the point of activation, however this did not always occur and some staff would cancel the call themselves.

Sources: Observation, interviews with several staff .

This order must be complied with by September 19, 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.