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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 23, 2024

Inspection Number: 2024-1142-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063412 Ontario Limited as General Partner of 2063412 Investment LP

Long Term Care Home and City: Creedan Valley Community, Creemore

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-25, 29-31, August 1-2 and August 9, 2024.
The inspection occurred offsite on the following date(s): August 8, 2024.

The following intake(s) were inspected:

- Intake: #00117024 Follow up to Compliance Order #001 -O. Reg. 246/22 - s. 96 (2) (g) regarding water temperatures from inspection #2024-1142-0002 with a compliance due date of June 27, 2024
- Intake: #00115833 follow up to Compliance Order #001 -FLTCA s.3.(1)19.i. regarding resident rights from inspection #2024-1142-0002 with compliance due date of July 5, 2024
- Intake: #00115103 an anonymous complaint regarding skin and wound care, safe transferring of residents and dining room service
- Intake: #00116381 an anonymous complaint regarding cleanliness of the home
- Intake: #00121725 an anonymous complaint regarding mould and leaking roof

- Intake: #00119466 regarding a fall resulting in an injury and change of status

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1142-0002 related to FLTCA, 2021, s. 3 (1) 19. i.

Order #001 from Inspection #2024-1142-0003 related to O. Reg. 246/22, s. 96 (2) (g).

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

1. 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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided care as per their plan of care.

Rationale and Summary
The plan of care for a resident stated they required adaptive aides during meal time to encourage fluid intake. Additionally they were to be offered hand wash wipes to clean their hands.

During a meal adaptive devices were not offered to the resident and their hands were not cleaned using the wipes as identified in their plan of care.

When staff did not follow the resident's plan of care for using the appropriate adaptive aides for fluids and cleaning supplies for their hands, it could have led to decrease fluid intake and dry skin.

Sources: Care plan, dietary referral record, interviews with staff and Director of Care.

WRITTEN NOTIFICATION: Conditions of License

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2024_1142_0002 served on May 9, 2024, with a compliance due date of July 5, 2024.

The licensee failed to implement corrective actions as outlined in the home's compliance plan that was required by the Ministry of Long-Term Care (MLTC).

Summary and Rationale
A) The licensee was required to prepare, submit and implement a plan to ensure that staff were involving residents in the development, implementation, review and revision of their plan of care to the MLTC by June 7, 2024.

The home's plan stated that education on the home's policies for plan of care, care conferences, consent, and capacity, would be completed with the care team at resident home area huddles.

The home did not complete the education with the members of the care team at the resident huddles by the compliance due date of July 5, 2024.

Sources: Review of MLTC corrective action plan submitted June 7, 2024, review of Town Hall slide deck and attendance, interview with registered staff members and Director of Care (DOC).

B) The home's compliance plan stated that residents were provided a copy of the home's "Move-in Guide" that outlined ways the team would collaborate with residents to participate in the development, implementation, review and revision of

their plan of care. Residents and families were encouraged to participate in care conferences, and the care team would continuously engage with residents and their loved ones at care conferences, health status updates and changes in health condition to ensure their needs were met.

A resident's annual care conference was held. The home's Resident Family Experience Coordinator (RFEC) confirmed that the resident was not offered or brought to the care conference and their family did not attend.

The home did not follow their compliance plan when they did not include the resident to participate in their annual care conference that was held to review and or revise their plan of care.

Sources: Review of the resident's interdisciplinary care conference assessment, progress notes, Move-In Guide, MLTC compliance plan due date of June 7, 2024, interview with RFEC.

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #002
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the

Act.

Compliance History:

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.

WRITTEN NOTIFICATION: Conditions of License

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed comply with Compliance Order #001 from inspection 2024-1142-0003 issued on May 24, 2024, with a compliance due date of June 27, 2024.

The water temperature monitoring policy was not updated to include the use of a calibrated thermometer, the amended policy for water temperature

monitoring/guidelines was not reviewed with all staff and the log of water temperatures was not fully completed.

Rational and Summary

The amended policy contained no information regarding the use of a calibrated probe thermometer. The Director of Environmental Services (DES) shared that there were no instructions or procedures regarding calibration of the probe thermometers.

The home had Water Temperature Monitoring Guidelines however they were not reviewed with all staff.

The DOC and Director of Environmental Services (DES) were identified in the home's compliance plan as the designated managers to monitor the log regularly to ensure that it is fully completed. There were no completed water temperature logs for 21 shifts over a 32 day period.

Sources: interviews with staff members, DOC, DES, ED, review of water temperature monitoring logs, Water Temperature Monitoring Policy and Guidelines revised June 2024, review of Town Hall slide deck and attendance, observations of water temperatures and Taylor probe thermometer.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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.

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure to keep a documented record of an email complaint including the nature of the written complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, the date and description of any response provided to complainant, as well as any response made in turn by the complainant.

Rational and Summary

The Complaints Management Program policy mandated any complaint (verbal, written, telephone, email, or text) received at the community or at support services office from residents, families, visitors, and team members was to be investigated, and actions were to be taken for resolution.

An email compliant was received by the home and there was no documented record kept in the home regarding the complaint.

When the home failed to keep a documented record of the email complaint and

failed to take action to resolve it, it prevented the home from tracking and monitoring complaints and could lead to the same concerns happening again.

Sources: Complaints binder, Complaints Management Program (ON) policy, interviews with staff and ADOC/IPAC lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #005 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 failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, April 2024, page 24, states that alcohol-based hand rubs (ABHR) are the first choice for hand hygiene when hands are not visibly soiled. They must not be expired.

Rational and Summary

During the inspection, observations done of the ABHR in all resident living areas of

the home were expired.

The IPAC lead stated that the ABHR was not to be in use if expired.

By using expired ABHR in the home it may not be effective in stopping the spread of infection.

Sources: observations and interview with IPAC lead.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. The Director of Care will create and implement a plan to ensure that an identified resident is transferred safely during their bath/shower. The plan shall include an assessment of the resident to determine if the current shower chair is adequate, and if not what actions were taken to ensure the resident has adequate showering equipment. This plan, outlining the date of

the assessment and who completed the assessment, along with any actions taken shall be documented and kept available in the home.

2. Educate all Personal Support Workers (PSW) who provide showers in the home on the home's Zero lift and Transfer Policy and the proper way that a shower is to be completed. This should include ensuring staff are aware not to shower residents while they are hanging in a sling above the tub. A record that includes the date the education was provided, who provided the education, staff who attended the education and the education contents will be kept available in the home.

3. The DOC or ADOC will conduct a weekly audit observing PSWs transferring the identified resident from a lift into a shower chair for their shower. The audit will include the date, the staff conducting the transfer and the equipment used. The audit will identify deficiencies and corrective action taken if the resident is being showered using improper or unsafe transferring and/or bathing techniques. This weekly audit is to be completed for a month at minimum or until no deficiencies are noted. The audit will be kept available in the home.

Grounds

The licensee has failed to ensure that two staff members were present while transferring a resident during their shower.

Rationale and Summary

Staff shared that a resident had been showered only by one staff member while being suspended from a ceiling lift with a sling about the tub and being sprayed down with water.

The Director of Care acknowledged that showering any resident by using a ceiling lift and a sling to suspend them over the tub and spraying them down with water was not acceptable.

The home failed to ensure that two staff were present while the ceiling lift was used to assist the resident. The resident was routinely showered by only one staff member while being suspended from a ceiling lift with a sling above the tub and sprayed with water.

Sources: Resident clinical records, Zero Lift & Transfer Policy, interviews with resident, staff and Director of Care.

This order must be complied with by

October 7, 2024

COMPLIANCE ORDER CO #002 Housekeeping

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The Inspector is ordering the licensee to prepare, submit and implement a plan

to ensure compliance with O. Reg. 246/22, s. 93 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:

1. How the home will ensure that all resident rooms, bathrooms, common areas, hallways, medication/treatment rooms, charting room, dining rooms are cleaned outlining processes for cleaning each room on a daily basis and monthly basis and how each housekeeper will document this work being completed.
2. How the Sienna Regional Housekeeping consultant will support the Director of Environmental Services to ensure that an organized program of housekeeping is implemented and maintained in the home. This shall include what audits are to be completed, frequency and how deficiencies identified will be followed up.
3. A procedure and schedule as to how common areas and hallway floors will be cleaned and maintained as per the organized housekeeping program.
4. A schedule as to how all resident rooms/bathrooms, common areas (lounges, library, dining rooms. tub rooms, hair dressing room) will have a deep carbing completed at a minimum of at least once yearly. The plan shall address how the home will get the remaining rooms/areas that have not had a deep carbing in 2024 completed.
5. The new schedules and procedures to be created in items 1-4 shall be in writing.
6. Address how housekeeping staff will be educated on the changes identified on items 1-4 above. Identify where a record of the education content will be kept, including who participated in the training.

Please submit the written plan for achieving compliance for inspection #2024-1142-0004 to the MLTC, by email to centralwestdistrict.mltc@ontario.ca by September 13, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home that included resident bedrooms, including floors, furnishings, and wall surfaces; common areas and staff areas, including floors, furnishings, contact surfaces and wall surfaces.

Rationale and Summary

During the inspection the following was observed:

· Dust and dirt at the edges of the floor in the hallways and behind doors

· Dust and dirt build up on floor in the Trillium Way medication room and the medication/treatment storage room on Lilly Way

· Dust and dirt build up at the edges of the floor in resident rooms, closets, library around room edges, behind vending machines located in the library, and lounge by the Trillium Way nursing station

· Dust and dirt build up in the ceiling vents in the library, hair salon, medication/treatment storage room on Lilly Way and resident wash rooms

· Black substance noted on the ceiling vent in Poppy Lane

· Soiled privacy curtains in the Poppy Lane Tub/Shower room

· Wax worn off floors in hallways with a yellowish build up of wax on floor edges noted throughout the home

· Drink spills noted on walls in resident rooms and on the Trillium Way medication room door

· Dead insects noted on the floors between the doors of the emergency exits

A review of the housekeeping binders showed that each resident room had a Daily Room Clean Checklist where staff checked that they dusted all furniture, tv, vents and lights; sanitize light switches, all door handles, call bells; clean window sills, baseboard heaters and behind the door; clean and sanitize the bathroom; check paper products, sweep/mop all floors; and initial when complete. A review of the checklists showed that these checklists were not completed everyday for every resident room.

Staff said that the High Touch Audit Calendar was to be signed each day when the high touch common areas were done daily. A review of the High Touch Audit Calendars for July 2024 were not signed as completed each day.

Staff said that each day of the week Housekeeper 1 (H1), Housekeeper 2 (H2) and Housekeeper 3 (H3) (H3 from Monday to Friday) do a daily carbing/deep clean of a resident room and a Daily Carbing/Deep Clean Checklist was completed. Each resident room was to be done monthly. A review of the Daily Carbing/Deep Clean Checklists showed that four rooms were completed in a month.

Staff said, usually on Mondays, one resident room had a full room carbing done. This included removing all furniture from the room, washing of curtains, cleaning windows, washing walls, stripping and waxing of floors and maintenance repairs needed were done. A Full Room Carbing Audit was completed and a schedule for each room was signed off when completed. A review showed that 14 resident rooms and audits were completed for the year, however there are 32 rooms remaining for 2024.

The DES said that they tried to schedule one or two shifts a month on nights to strip and wax floors in hallways and common areas but that was not always possible due to staffing.

A review of the audits for 2024 showed one Common Area Cleaning Audit, one Housekeeping Safety Audit, one Resident Room Housekeeping Audit and one Environmental cleaning Audit of High Touch Surface Areas were completed. There was no schedule as for when audits were to be completed.

A review of the Housekeeping H1, H2 and H3 job routines did not include cleaning of medication rooms and treatment rooms. There was no schedule as to when the common areas such as the lounges, library, hair dressing room, tub rooms and dining rooms were to have a deep carbing/clean done.

Failure to implement an organized program of housekeeping in the home has created adverse conditions in the home as lack of cleanliness does not promote high quality accommodations and the residents' rights to live in a safe and clean environment.

Sources: Observations July 22, 24, 29, 30, 31, and August 1, 2024; review of Audits, Housekeeping shift routines, Housekeeping binders, Deep Cleaning of Common Areas-Housekeeping Policy; Rotational Cleaning-Housekeeping Policy; Daily Resident Room Cleaning-Housekeeping Policy; Resident Room Housekeeping Audit; Common Area Cleaning Audit; Housekeeping Safety Audit Form; Environmental Cleaning Audit of High Touch Surface Areas; interviews with staff and DES.

This order must be complied with by

October 18, 2024

COMPLIANCE ORDER CO #003 Maintenance services

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

Maintenance services

s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

1. Develop and implement a policy and procedure regarding roof maintenance. The procedure shall also include a preventative component (an auditing process) to ensure that routine roof maintenance is being completed and that the roof is maintained in a good state of repair.
2. Have Midhurst Roofing Limited or another professional roofing company complete a full roof inspection including water leak testing of the entire roof to determine the cause of leaking and what replacement or repairs of roofing/shingles etc. need to be made to prevent further leaking of the roof. A copy of the full roof inspection report shall be kept available in the home.
3. Review the roof inspection report and develop and implement a plan to immediately prevent or mitigate the leaking in resident room 25, entrance to the back dining room from the Trillium Way hall, Trillium Way kitchenette, front dining room, around ceiling vent in Poppy Lane hallway by room 60 and any other areas identified in the report. The plan shall include the date action will be taken, a description of the location of the problem, a description of the

actions to be taken, and the person(s) responsible for implementing the interventions and actions. A record of the plan shall be kept available in the home.

Grounds

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

In accordance with O. Regulation 246/22, s. 11(1) (a), the licensee is required to ensure that the procedures and schedules are in compliance and implemented in accordance with applicable requirements under the Act, specifically s. 19(1)(c).

Rationale and Summary

During the inspection the following observations were made:

· Water stained ceiling tiles noted in Lilly Way hall outside of the common resident washroom and outside the medication/treatment room; by the nursing station on Poppy Lane and by the ceiling vent by room 60; in Trillium Way hallway by room 25 and the entrance to the back dining room; and in the Kitchenette by the back dining room.

· The water stained ceiling tiles near the nursing station on Poppy Lane, in the Lilly Way hall outside the common washroom were noted to have mould growth.

· On days when it was raining, water was leaking:

a) from the ceiling in the front dining room in front of the fireplace and two buckets were in place to catch the water

b) from the split mini air unit between room 25 and 27, a bucket and towels were on the floor

c) from the ceiling in resident room by the closet and a bucket and towels were on the floor

d) from the ceiling in the hallway outside of room 25 and 26, buckets were in place to catch the water

e) from the ceiling at the entry to the back dining room with buckets, towels and table clothes on floor to catch the water

f) from the ceiling in the back dining room kitchenette with a bucket on top of the wall refrigerator unit, and on the floor there were buckets and towels to catch the water. On one occasion water was dripping on the black Rubbermaid cart and collecting on top of the cart

g) from the ceiling vent in the hallway near room 60 with a bucket and towels on the floor

h) from the exit sign outside of the treatment/medication room in Lilly Way hallway with buckets and towels on the floor

i) from the ceiling in the treatment/medication room in Lilly Way hallway with buckets and towels noted in corners and on the counter top. Medical supplies on the shelf were wet.

A resident said that their ceiling in their room had been leaking for at least three years.

During interviews with staff members they said that the ceiling had been leaking for more than two years. They said that the number of areas where the ceiling was leaking had increased.

The DES stated that every time that it rains they had to go on the roof and use the two pumps to pump water off of the roof. Even with pumping the roof the leaking continued to happen.

The Manager of Building Services for Sienna shared that a roof inspection has not been done.

The licensee did not have a policy and procedure for roof maintenance. There were no maintenance audits regarding the roof.

Failure to develop and implement a maintenance program regarding the home's roof has created adverse conditions in the home which does not align with the fundamental principle under the Fixing Long Term Care Act to promote high quality accommodation to live in a safe and comfortable environment.

Sources: Observations July 22, 24, 29, 30, 31, and August 1, 2024, interviews with resident, staff members, DES, Manager-Building Services (Sienna), invoices of roof repairs from January 2022 to August 8, 2024.

This order must be complied with by

October 18, 2024

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.