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

Ottawa District
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Original Public Report

Report Issue Date: June 25, 2024	
Inspection Number: 2024-1352-0002	
Inspection Type: Complaint Follow up	
Licensee: CVH (No. 4) 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: Manoir Marochel, Ottawa	
Lead Inspector Megan MacPhail (551)	Inspector Digital Signature
Additional Inspector(s) Lisa Kluke (000725)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14, 15, 16, 17, 27, 28 and 29, 2024.

The following intake(s) were inspected:

- Intake: #00111610 was a complaint related to concerns about the care of residents.
- Intake: #00111954 was follow up #1 to Compliance Order (CO) #001 from inspection #2024-1352-0001, related to O. Reg 246/22, s. 12 (1) 3, with a Compliance Due Date (CDD) of April 23, 2024.
- Intake: #00111956 was follow up #1 to CO #002 from inspection #2024-1352-0001, related to FLTCA, 2021, s. 5, with a CDD of April 16, 2024.

- Intake: #00114075 was a complaint related to concerns about the care of a resident.
- Intake: #00114947 was a complaint related to concerns about the care of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1352-0001 related to O. Reg. 246/22, s. 12 (1) 3. inspected by Lisa Kluke (000725)

Order #002 from Inspection #2024-1352-0001 related to FLTCA, 2021, s. 5 inspected by Lisa Kluke (000725)

Order #002 was not complied by the compliance due date (CDD) of April 16, 2024, but was complied between the CDD and the completion of follow up inspection #2024-1352-0002. As a result, Administrative Monetary Penalty (AMP) #001 related to Written Notification #003 was served to the licensee.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the plan of care provided clear directions to staff and others who provided direct care to a resident.

Rationale and Summary

A resident had a device to assist in managing their urinary needs.

Specific tasks were created in the Point of Care (POC) system to provide directions for the Personal Support Workers (PSWs) on how to care for the device.

A task was not created for the PSWs to record the volume of output from the device on every shift.

As per the Director of Nursing and Personal Care (DONPC), a custom task should have been created to prompt the PSWs to record the volume of output from the device on every shift.

By not creating a task for the PSWs to record the volume of output on every shift,

the output was not consistently documented, and a baseline of output was not established.

Sources: Review of a resident's health care record and interview with the DONPC. [551]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 the care set out in the plan of care was provided to a resident.

A) Rationale and Summary

A resident was ordered daily vital sign monitoring.

In an interview with the DONPC, they stated that daily vital sign monitoring was not completed as ordered.

As the resident's vital sign was not monitored on a daily basis, assessing the need for or the adequacy of a treatment, using the prescribed parameter, may not have been possible.

Sources: Review of a resident's health care record and interview with the DONPC.

[551]

B) Rationale and Summary

A resident was ordered a test.

In an interview with the DONPC, they stated that the test was not completed as ordered.

The test, which could have suggested the presence of infection or not, was not completed as ordered,

Sources: Review of a resident's health care record and interview with the DONPC.
[551]

WRITTEN NOTIFICATION: Conditions of Licence

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 has failed to comply with Compliance Order (CO) #002 from Inspection #2024-1352-0001, served on March 21, 2024, with a compliance due date (CDD) of April 16, 2024.

CO #002 was not complied by the CDD of April 16, 2024, but was complied between the CDD and the completion of follow up inspection #2024-1352-0002.

The process to ensure that, any slide bolt latch lock found on the outside of resident-accessible washroom doors was removed, was not fully complied with until May 14, 2024.

Rationale and Summary

A slide bolt latch lock was observed on the outside of a resident's bathroom door during a tour of residents' bedrooms.

The Administrator indicated that they had completed a tour of every bedroom and requested each of the slide bolt locking mechanisms be removed, however one was missed.

Failing to comply with conditions of the CO to remove all slide bolt latch locks on the outside of the residents' washroom doors presented the continued risk of a resident being locked or trapped in the washroom without the ability to release the lock from the inside as indicated in the original CO.

Sources: Observations and interview with the Administrator. [000725]

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 #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:
Prior non-compliance with FLTCA, 2021, s. 5, resulting in CO #002 in inspection #2024-1352-0001, issued on March 21, 2024.

CO #002 was not complied by the compliance due date (CDD) of April 16, 2024, but was complied between the CDD and the completion of follow up inspection #2024-1352-0002. As a result, Administrative Monetary Penalty (AMP) #001 related to Written Notification #003 was served to the licensee.

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: Communication and Response System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 20 (g)
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,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that, in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary

When a resident's RSCRS cord was pulled out of the wall unit, there was no auditory alert to staff. Only the dome light outside of the resident's room could have alerted staff that the RSCRS had been activated.

A Registered Practical Nurse (RPN) indicated that there should have been an auditory alert, and they reported that the RSCRS was not functioning properly to the DONPC.

The DONPC and Administrator indicated that the RSCRS was equipped with an audible alarm to alert staff when a resident or staff member required assistance, however the system had been silenced.

The home's RSCRS used sound to alert staff. Failing to have a level of sound that was audible to staff potentially posed a delay in response to calls for assistance.

Sources: Observations and interviews with staff. [000725]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (1) 4.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that a required supply was available when a resident's device was ordered to be changed.

Rationale and Summary

A resident had a medical device, and the device was ordered to be changed at specific intervals.

On the day that the device was ordered to be changed, a required supply was not available, and a different date was scheduled for it to be changed.

The lack of a required supply prevented the device from being changed as ordered.

Sources: Review of a resident's health care record and interview with staff. [551]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The licensee has failed to comply with the home's system, included in the required Nutritional Care and Hydration Programs, to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

In accordance with O. Reg 246 / 22, s. 11. (1), the licensee was required to ensure that the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration was developed for the Nutritional Care and Hydration Programs, and they were to ensure that it was complied with.

Specifically, staff did not monitor the food and fluid intake of a resident.

Rationale and Summary

A task was created in POC for the PSWs to monitor the percentage of food and the quantity of milliliters consumed by a resident at meals and snacks.

A review of the resident's health care record indicated that during the period of approximately one week, the resident's intake of food and fluid was not monitored at these meals and snacks:
Twice at breakfast.
Three times at lunch.
Twice at supper.
Once at the afternoon snack.
Twice at the evening snack.

Their intake of fluids was not monitored twice at the morning snack.

The DONPC stated that the food and fluid intake of all residents should have been monitored at all meals and snacks.

By not complying with the system to monitor the food and fluid intake of the resident, there may not have been an accurate record of their intake, which would have been used to enable appropriate nutrition and / or hydration interventions, as required.

Sources: Review of a resident's health care record and interview with the DONPC. [551]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (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 or protocol issued by the Director with respect to infection prevention and control (IPAC) was complied with.

The licensee failed to ensure that that Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee did not ensure that Additional Precautions included, at a minimum, additional Personal Protective Equipment (PPE) requirements including the appropriate selection application, removal and disposal of PPE, as is required by Additional Requirement 9.1 (f) under the IPAC Standard.

A) Rationale and Summary

Specific Additional Precautions were posted for a resident due to the use of a procedure that generated aerosols.

Directions on the signage specified the use of an N95 mask, eye protection, gloves and a gown, and to keep the room door closed when the procedure was in progress and for a settling time. The IPAC Lead stated that the settling time, post procedure, was three hours.

Eye protection was not observed in the PPE storage container outside of the resident's room.

There were inconsistencies in who was responsible for stocking which PPE supplies,

and not all staff were aware of the need to wear PPE when providing care to the resident if the procedure was in use or had been in use in the three hours prior. Staff stated that eye protection was not consistently available or worn when required.

Sources: Observations and interviews with staff. [551]

B) Rationale and Summary

A member of the registered nursing staff was observed entering a resident's room where specific Additional Precautions were posted without wearing any PPE.

They indicated that they should have worn the appropriate PPE due to the specific Additional Precautions that were in place at the time.

Staff were at potential risk of exposure to infectious agents when they were not wearing the PPE required for the specific Additional Precautions. Residents were at risk of exposure to potentially infectious agents from staff.

Sources: Observations and interview with staff. [000725]

WRITTEN NOTIFICATION: Medication Management System

NC #008 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 comply with the written policy and procedure for the medication management system with a resident's medication.

In accordance with O. Reg. 246 / 22, s. 123 (3), the licensee was required to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, a member of the registered nursing staff did not comply with the Medication Management policy when a resident was left with their oral medications.

Rationale and Summary

A resident was laying in bed with medication tablets on them and in a medicine cup. They stated that they were waiting for the nurse to return to tell them what the medications were, and that some nurses left the medications with them and other waited until they swallowed them. The resident proceeded to take their medication as it had been 15 minutes since the nurse had left.

The Electronic Medication Administration Record (eMAR) provided specific instructions on how to administer the resident's medications, including that a specific medication was to be crushed. It did not indicate that the resident could be left with their medications. The resident's medications were signed for as having been administered.

The member of the registered nursing staff stated that they had not crushed the specific medication and had not returned to see the resident as they were completing the medication pass.

A co-resident stated that they received their oral medication in a medicine cup in

the morning, and they brought them to the dining room and took them with their breakfast on their own every morning.

The DONPC provided the Policy and Procedure for Medication Management. These procedures indicated:
- Registered nursing staff were required to observe medication have been ingested, otherwise they cannot be considered administered.
- Do not leave medication unattended for the resident to self-administer unless the resident performs self-medication administration in adherence to the "Self-Administration of Medication Policy", and
- Immediately document all medication administered after administration on the MAR / eMAR by the administering nurse.

The DONPC indicated that no resident in the home was to be left unattended with their oral medications. Registered nursing staff were required to stay with residents until the medications were administered to then be able to document this in the EMAR.

Failing to follow the policy and procedures regarding the practice of leaving oral medications with a resident posed a potential risk of the resident not taking or loosing them.

Sources: Observations, interviews with residents and staff and review of the Policy and Procedure for Medication Management. [000725]

COMPLIANCE ORDER CO #001 Availability of Supplies

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

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

a) Conduct a review of the organized laundry program to ensure that a sufficient supply of clean linen, cloths and towels are always readily available in the home for use by staff and residents, to meet the nursing and personal care needs of the residents in the home. The review shall include, at a minimum,
i) complete a linen inventory, including a search of all areas of the home,
ii) determine the quota that is required for every shift,
iii) develop and implement written procedures to ensure a sufficient readily available quota for every shift,
iii) develop and implement a rewash and discard process for worn and / or stained linens, cloths and towels,
iv) develop and implement a formalized process for requesting additional clean linen, cloths and towels, with established timelines and procedures for receipt of requested items.

b) Conduct once a week audits of the availability of clean linen, cloths and towels, ensuring that the supplies are readily available on the care units to meet the

personal needs of the residents.

c) Conduct once a week audits of every resident bedroom, on alternating shifts, to ensure that the resident has at least one of each clean linen item, such as facecloth, hand towel, bottom sheet (if required), maxi slide lift sheet (if required), top sheet, bedspread, blanket, and pillowcases for the number of pillows used for these residents until this order has been complied, and

d) Provide documentation to support that action has been taken in regard to (a) through (c), and any other action that the home determined was necessary in order to ensure that linen supplies were readily available to meet the personal care needs of their residents.

Documentation is to continue until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this Compliance Order.

Grounds
The licensee has failed to ensure that resident linen supplies were readily available to meet the nursing and personal care needs of the 64 residents in the home.

Rationale and Summary

Staff indicated that they were often short linen, cloths and towels that were used to meet the personal care needs of residents. They had to check in the laundry room for extra and rarely found more. When there were not enough top and/or fitted sheets and blankets, other linens had to be used to make residents' beds. When there were not enough cloths, disposable wipes were used for personal care. The Laundry Attendant indicated that they washed linens, cloths and towels as fast as they could to return it three times a day.

The Dietary / Environmental Manager indicated that based on a recent inventory list, the home did not have enough linen, cloths and towels for their 64 resident and would be required to order a sufficient supply for residents on all three shifts.

The linen closets in both wings in the home had limited supplies. Residents' beds had one bottom sheet and bedspread often or no sheets, as staff were waiting for laundry to supply clean linens. The laundry room did not have an extra supply of linens, other than what was inside the washing machines or dryers, during observations.

The inventory lists for a period of one week were reviewed, and they indicated that for linen supplies, such as face cloths, hand towels, bath towels, top sheets, bottom sheets, pillowcases, bedspreads and blankets, the number of each item washed on average, for the whole home, was below 30, which would account for half of the residents in the home, per shift.

Failing to ensure that there was a sufficient supply of linens, cloths and towels readily available for all residents of the home may have increased the risk of not meeting the nursing and personal care needs of the residents.

Sources: Observations, interviews with staff and review of the inventory lists for a seven-day period. [000725]

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #002 Housekeeping

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 93 (2) (b)
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:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;

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

a) Provide education and review with all nursing staff the licensee's policy and procedures for the cleaning and disinfection of surfaces for tub and shower units and tub and shower equipment, in accordance with manufacturer's specifications, and document that this education was provided,

b) Immediately develop a procedure for Housekeeping to ensure a cleaning / disinfectant product is available in every shower unit, and ensure this procedure is implemented,

c) Conduct once a week audits of these tub and shower units, ensuring that the cleaning supplies are readily available and used by nursing staff as per policy. These audits will include the name of person who completed the audit, and the date and the time when each audit was conducted to support that a member of the management team or delegate has conducted these audits. The audits will be performed until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this Compliance Order,

d) Ensure all signage inside tub and shower rooms are in accordance with current policies and procedures, and that they provide clear directions for staff.

Grounds
The licensee has failed to ensure that procedures for the cleaning and disinfection of surfaces were implemented for tub and shower units and tub and shower equipment in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Some PSWs were using sanitizing wipes to clean tub and shower equipment in the home. They were unaware of the specific instructions displayed on the wall for cleaning the bathtub, shower, and equipment surfaces, or they did not know the required contact or standing time for these procedures. They reported that the south tub and shower rooms lacked long-handled cleaning brushes, resulting in these areas and their equipment being cleaned only with a cleaning solution followed by a water rinse. Cleaning / disinfectant spray bottles had been unavailable in both the south and west shower rooms for an extended period. The PSWs asked housekeeping to clean the shower units.

A Housekeeper indicated that they were not responsible to refill or replace any spray bottle in the shower rooms, and that the shower unit was cleaned after nursing staff completed their showers for the day, and not after every resident's shower.

In the south tub room, a wall mounted cleaning solution was observed. The tub room lacked a long-handled scrub brush. Signage on the wall next to the wall mounted device indicated that tubs had to be cleaned and disinfected after each use by spraying the entire tub surface and lift with cleaner / disinfectant and cleaning them with a brush; rinsing the tub and lift after cleaning; re-straying the clean tub and lift with same product and allowing it to stand for 10 minutes. Signage in the shower rooms indicated the need for cleaning and disinfecting the shower and equipment. In the south wing, a long-handled brush and a spray bottle with cleaning solution were not provided.

The Manufacturer's label for the wall mounted cleaning solution indicated that it was to be applied with a cloth, sponge or mop, let to sit for two to three minutes, wiped clean and rinsed thoroughly with potable water.

The policy for tub and spa room cleaning required that the bathtub be cleaned with germicidal cleaner after each resident's bath following the manufacturer's instruction, and to clean the shower units with germicidal cleaner after each resident's shower.

The policy for cleaning shower chairs and commodes required wetting all surfaces of the equipment with warm water, scrubbing away all organic material using a long-handled brush, rinsing with warm water, and then wiping the equipment from top to bottom with disinfectant wipes in an S-shaped motion; and using an approved cleaning solution, dispense the solution onto all surfaces of the equipment; the

product must remain on the equipment for the contact time specified by the manufacturer's guidelines. The Footnotes to this policy indicated the chemical must remain on surface for entire kill cycle / contact time, and that two-step clean was a process used to clean and then disinfect surfaces.

The absence of cleaning and disinfectant products, as well as cleaning tools that complied with manufacturers' instructions and the nursing staff's understanding of the licensee's policies and procedures, presented a potential risk for cross-contamination among residents using the tub and shower units and equipment.

Sources: Observations of south and west tub / shower rooms, interviews with staff and review of posted signage and policies and procedures. [000725]

This order must be complied with by August 7, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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

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.