

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: December 5, 2025
Original Report Issue Date: December 3, 2025
Inspection Number: 2025-1352-0003 (A1)
Inspection Type: Complaint Critical Incident 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

AMENDED INSPECTION SUMMARY

This report has been amended to:
Written Notification (WN) #001 was amended to indicate this WN has been referred to the Director for further action by the Director.

Compliance Order (CO) #002 was amended to indicate this CO has been referred to the Director for further action by the Director.

Compliance Orders #001 and #003 are included in this report for reference; however, were not amended; therefore, the served date remains December 3, 2025.

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Complaint
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Compliance Orders #001 and #003 are included in this report for reference; however, were not amended; therefore, the served date remains December 3, 2025.

INSPECTION SUMMARY

The inspection occurred onsite on October 20-24, 27-31, 2025, and November 3-7, 10, 12-14, 17-20, 2025.

The inspection occurred offsite on November 24, 25, 2025.

The following intake(s) were inspected:

Intake #00146347/FU#1 to CO 001 from inspection #2025-1352-0001 related to s. 19 (2) (a) accommodation services of the organized program of housekeeping for the home issued April 30, 2025, with a final Compliance Due Date (CDD) of September 15, 2025.

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Intake #00158065/FU #1 to CO 002 from inspection #2025-1352-0002 related to maintenance services procedures for water temperatures issued September 16, 2025, with a final CDD of October 20, 2025.

Intake #00158631 was an anonymous complaint regarding a medication incident involving a resident.

Intake #00161029 was an anonymous complaint regarding the availability of linens for resident care.

Intake #00161666 regarding an incident when a resident was injured and taken to hospital that resulted with significant changes to the resident's health status.

Intake #00162942 regarding a medication incident with adverse drug reaction to a resident.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1352-0001 related to FLTCA, 2021, s. 19 (2) (a) was inspected.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #002 from Inspection #2025-1352-0002 related to O. Reg. 246/22, s. 96 (2) (g) was inspected.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must comply

NC #001 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 #2025-1352-0002 served on September 16, 2025, with a compliance due date of October 20, 2025.

As required by the order the licensee was to ensure that the temperature of the water serving all hand basins used by residents did not exceed 49 degrees Celsius (°C), and to investigate and implement long-term corrective actions that does not solely rely on continuous monitoring and adjustments to the mixing valves to regulate the temperature. In addition, the order also required the implementation of a monitoring program to ensure that all resident hand basins are tested at least once within every seven-calendar day cycle.

Specifically, elevated water temperatures were recorded exceeding 49°C at a resident's hand basins on a specified date. The following day, two additional hand basins were found to have water temperatures above 49°C. On another date, two hand basins were found to have water temperatures above 49°C, exceeding the acceptable threshold.

During an interview with an Administrator, they confirmed that the home implemented the monitoring program (audits) of the water temperature within a 30 day cycle instead of the required seven day cycle, and those audits did not identify any water temperatures exceeding the required range. Additionally, the Administrator stated that long-term corrective actions beyond ongoing monitoring and adjustments to the mixing valves was not implemented, as no alternative process was available.

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Sources: Observations of water temperatures of hand basins in residents rooms;
interviews with an Administrator; review of homes water temperature log.

This Written Notification is being referred to the Director for further action by the Director.

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 #001

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:

In the past 36 months, a CO under O.Reg 246/22 s.96(2) (g) was issued in inspection #2025-1352-0002 on September 16, 2025 and this was not complied.

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.

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WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)

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:

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On a specified date during this inspection, three resident's wheelchairs were observed to be visibly soiled. On the following day, four resident's wheelchairs and a walker were observed to be visibly soiled with unknow dried matter. These resident's mobility devices were not cleaned and disinfected and it was determined that there was no procedure developed and implemented for the routine cleaning and disinfection of residents' mobility devices.

Sources: interview with an Administrator; inspector's observation.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 5.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

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A resident had adverse drug reactions documented in their health records after receiving the wrong dose of a specified medication for a 34 day period that required hospitalization a number of times in this period with deterioration in health. The Director was informed of the medication incident 46 business days after the occurrence of the incident.

Sources: Review of resident health care records, the medication incident related to this resident, pharmacy documentation for adverse reactions; interviews with two Southbridge Nursing Consultants and an Administrator.

WRITTEN NOTIFICATION: Medication management system

NC #004 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.

The licensee's specified written policies and protocols for medication management were not implemented for a resident.

The Change Order policy was not implemented in that a medication was processed and verified inaccurately. This inaccurate medication was dispensed to the home.

The Receiving Medications policy indicated the medication delivered and prescriptions received from the pharmacy are verified by registered nursing staff for accuracy by reconciling medication received against the drug record of ordering. The medication reconciliation was not completed by registered nursing staff to identify the error in dosage of this medication prescribed for a resident. The medication received and electronic medication administrator record (EMAR) for this resident were not revised for the correct dosage of this medication.

The registered nursing staff failed to identify the error in the orders listed on the EMAR

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before administering the medication to this resident. This occurred because their verification process for ensuring complete and accurate drug information was not followed as outlined in their Medication Administration and Documentation policy. This medication was administered to the resident 34 times until this medication error was identified by the pharmacy.

Sources: Resident health records reviewed, Medication incident report, pharmacy policy and procedures for change orders, receiving medications, new medication orders, and medication administration and documentation; interviews with two RPNs, a Southbridge nursing consultant, and the Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

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

Non-compliance with: O. Reg. 246/22, s. 147 (2)

Medication incidents and adverse drug reactions

s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,

(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

(b) corrective action is taken as necessary; and

(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The medication incident involving a resident on a specified date with adverse drug reaction, did not have any review, analysis or corrective actions taken for education to registered nursing staff or procedures related to this incident to date.

Sources: Resident health care records reviewed, medication incident report; interview with DOC.

COMPLIANCE ORDER CO #001 Administration of drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

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Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

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

The licensee shall:

- 1) Provide training to all Registered Nursing Staff (RPNs and RNs) on the homes medication administration program, specifically related to their pharmacy policies related to management of new orders, change in orders, receiving of medications and medication administration and documentation policy and procedures. Maintain a written record of the training material provided, including the date the training was received and the name of the person providing this education;
- 2) Develop, implement, and document a plan to ensure Registered Nursing staff complete the required procedures from the policies listed in #1. Take remedial action if procedures are not implemented and ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber;
- 3) Maintain a written record of the documentation review from #2, the findings, any corrective actions taken and the outcome of the corrective actions.

Grounds

Drugs administered to a resident were not in accordance with the directions for use specified by the prescriber. A resident was prescribed specified dosage of a medication to begin on a specified date, however they were administered a different dosage of this medication daily for 34 days. This resident exhibited adverse drug reactions with hospitalizations in this period.

Sources: Resident health records reviewed including electronic Administration Records (EMAR), hospital discharge orders for prescriptions, physical chart review, pharmacy adverse drug reactions for this medication; interviews with the resident, two RPN's, a Registered Nurse (RN), a pharmacy consultant, a Nurse Practitioner (NP) and a

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Southbridge nursing consultant.

This order must be complied with by January 16, 2026

COMPLIANCE ORDER CO #002 General requirements

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

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:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

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

The licensee shall:

- 1) Upon receipt of this Compliance Order (CO), ensure the ED (Administrator) and the Environmental Services Manager (ESM) immediately review all existing policies and procedures of the laundry services program;
- 2) Within two weeks of receiving this CO, ensure that all existing policies and procedures for linen supplies for residents are fully implemented. Additionally, train laundry staff, PSWs, and any other nursing staff involved, so they understand their roles and responsibilities for keeping linen available;
- 3) Review and revise the home's laundry procedures to ensure sufficient time is allotted to laundry staff to complete all daily tasks required;
- 4) All required actions in this CO are to be documented including the date, the time, the names of the person's conducting and completing these reviews for (1) (2) and (3), as

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well as the documented material used for this review.

Grounds

The written organized program of laundry services under clause 19 (1) (b) of the Act, was not complied, in that their laundry programs' relevant policies, procedures and protocols were not implemented.

The licensee's policies Clean Linen Management or Monitoring of Linen Supplies were not complied with, in accordance with Ontario Regulation 246/22, s. 11 (1) (b): These policies indicated the home's commitment to ensure adequate monitoring of linen supplies to meet each residents' needs and support laundry services best practices, and these were not complied. The following procedures for both policies were not complied with:

-The Executive Director (Administrator) did not oversee the implementation and effectiveness of the laundry services program within the home, or conduct regular reviews of the laundry department audits with corrective action plans to ensure program compliance and performance improvement.

-The Environmental Services Manager (ESM) did not complete audits to ensure compliance and excellence in service delivery of linen, or review laundry audits and develop corrective action plans to address this shortage of resident linens. The ESM did not determine linen inventory audits or complete the Southbridge (SB) Linen Inventory Standards and Quotas. The ESM did not monitor and replace linens as required by completing their Linen Purchase Record as required. The ESM did not complete any Linen Purchase Record for budget preparation for the purchase of new linens to meet the residents' needs. The ESM did not implement the RHA-Clean Linen Daily Distribution list with laundry staff.

-The laundry staff did not report all linen shortages to the ESM immediately to obtain additional clean linen from the contingency supply to ensure adequate supply of clean linen is always available to staff. The laundry staff did not document daily on their Linen Count per Floor document for tracking clean linens brought to the floors for use by residents.

The overall failure to implement these program policies and procedures led to a

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significant shortage of linen supplies required for personal care to residents in the home.

Sources: Review of the Southbridge (SB) Laundry program policy and procedures with their appendices, the per item quota document in place at that time, the laundry binder and documents called Linen Count for South and West sides 2025, Linen Discarded audit 2025 binder and documents and RHA cart clean linen daily distribution list; Interviews with two ESMS, the SB Environmental Services manager lead, two Laundry staff, five PSW staff, an RPN, two Administrators, a Southbridge Nursing consultant and the Regional director for Southbridge.

This order must be complied with by January 30, 2026

This compliance order is being referred to the Director for further action by the Director.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$2200.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Non Compliance (NC) for O.Reg.246/22 s. 34. (1) 1 was issued in inspection #2025-1352-0001 on April 30, 2025, and then re-issued in inspection #2025-1352-0001 from

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their Follow Up Inspection with a base amp on September 16, 2025.

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

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

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

COMPLIANCE ORDER CO #003 Availability of supplies

NC #008 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 prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 48 [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit, and implement a plan to ensure that linen supplies are readily available at the home to meet the nursing and personal care needs for their 64 residents in the home.

The plan must include but is not limited to:

1)How the home will audit the entire home linens for residents to: review total number of each item in the home, review quota requirements in their policy and procedures and how the ordering of linens as per the home's laundry program requirements;

2)How the home will maintain the required linens quotas in the home;

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3) How the home will ensure the linen requests/auditing documentation from nursing or laundry staff will be monitored and actioned.

Please submit the written plan for achieving compliance for inspection #2025-1352-0003 to a LTC Homes Inspector, MLTC, by email by December 12, 2025.

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

Grounds

Resident linen supplies were not readily available at the home to meet the nursing and personal care needs of the 64 residents in the home.

The home submitted a critical incident regarding an allegation of neglect for lack of linen supplies to provide care to their residents. An audit was completed on the day of this incident report of linen in the whole home, noted a significant insufficient linen supply that would not cover one of their three shifts for care needs to their residents for a 24 hour period.

PSW's indicated they have had insufficient supply of linen for care of residents for over eight weeks and management were made aware regularly without solutions provided for PSW staff. Nursing staff were not aware of any documented request for linen or this procedure. Linen quota for clean linen brought to resident units from laundry staff were significantly below as per their documented linen logs over a six week period reviewed. These documented linen logs were below the home's "linen quota per day" requirements for resident care for each shift.

Sources: Observations of laundry room, linen closets, new linen storage closet and garage storage space; record review of binder for daily linen count for the home areas for 2025, the binder for discard log for linens for 2025, the daily linen quota requirements in place at the time, linen order forms for an 11 month period; interviews with two residents, five PSWs, an RPN, a maintenance staff, a laundry staff, an ESM, an office manager, the Director of Care (DOC), two Administrators, two Southbridge (SB) nursing consultants and the Regional Director for SB.

This order must be complied with by January 19, 2026

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An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #003

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #003
Related to Compliance Order CO #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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

An AMP is issued as there was a Compliance Order (CO) issued under the LTCHA in the past 36 months. Non Compliance for O.Reg. 246/22 s. 48 was issued in #2024-1352-0002 on June 25, 2024.

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.

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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

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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.



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Fixing Long-Term Care Act, 2021**

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