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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 25, 2022
Inspection Number 2022_1608_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Lambton

Long-Term Care Home and City
Marshall Gowland Manor, Sarnia

Lead Inspector
Julie Lampman (522)

Additional Inspector(s)
Tatiana Pyper (733564)

Inspector Digital Signature
Julie Lampman
Digitally signed by Julie Lampman
Date: 2022.08.30 09:47:38 -04'00'

Inspection Manager Tawnie Urbanski (754) was also present on July 13 and 14, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, and 18, 2022.

The following intake(s) were inspected:

- Intake #010020-22 (CIS #M613-000016-22) related to responsive behaviours.
- Intake #008514-22 (CIS #M613-000015-22) related to abuse and neglect.
- Intake #005547-22 (CIS #M613-000011-22) related to falls preventions.
- Intake # 004034-22 (CIS #M613-000008-22) related to falls preventions.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Safe and Secure Home

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INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 24 (1).

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Inspector #522 observed a resident dressed in extra layers, walking in a resident home area. The resident stated to Inspector #522 that they were cold.

Maintenance Staff (MS) #114 and Environmental Services Supervisor (ESS) #113 completed temperature checks of two home areas with Inspector. Temperatures in resident rooms, resident common areas and hallways were all below 22 degrees Celsius.

MS #114 stated they would turn off the air conditioning on those home areas and let the fans run to bring the temperature up.

Two days later, MS #114 competed temperature checks with Inspector for the same home areas and temperatures were all above 22 degrees Celsius.

Sources: Observations of resident home areas, interview with resident #004, Maintenance Staff #114, Maintenance Staff #126 and Environmental Services Supervisor #113.

Date Remedy Implemented: July 6, 2022 [522]

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (9) 1

The licensee has failed to ensure that staff documented the use of a resident's falls prevention intervention.

A resident's care plan noted the resident was to have a specific intervention in place as a falls prevention strategy.

Review of the resident's Documentation Survey report noted there was no task for staff to document the falls prevention intervention.

The Acting Director of Care acknowledged there was no task for staff to document the falls prevention intervention.

Review of the resident's Documentation Survey report noted the task had been added for staff to document the falls prevention intervention.

Date Remedy Implemented: July 18, 2022 [522]

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: FLTCA, 2021 *s. 6 (10).*

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
Personal Support Worker (PSW) #125 stated a resident was to have a specific falls intervention in place.

The resident was observed without the falls intervention in place. PSW #125 located the resident's falls intervention and applied it to the resident.

A review of the resident's care plan and kardex with PSW #106 noted that the falls intervention was not included as a falls prevention strategy. PSW #106 acknowledged that the resident used the specific falls intervention and that it should have been included in their care plan and kardex.

Sources: Observations of a resident, review of the resident's clinical records, and interviews with PSW #106, PSW #125 and the Acting Director of Care.

[522]

WRITTEN NOTIFICATION PLAN OF CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s.6 (7).*

The licensee has failed to ensure that a specific falls intervention was in place for a resident.

Rationale and Summary
The resident's plan of care stated that a specific falls intervention should be in place for the resident.

Review of a note in Point Click Care, noted that RN #135 forgot to apply the specific falls intervention to the resident.

During an interview with RN #135, they confirmed that the plan of care was not followed for the resident. RN #135 confirmed that the specific falls intervention was not in place for the resident.

Sources:
Review of the resident's clinical records and plan of care, and interview with RN #135.

[733564]

WRITTEN NOTIFICATION AIR TEMPERATURES

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

Non-compliance with: O. Reg. 246/22 s. 24 (3).

The licensee has failed to ensure that temperatures required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

Inspector #522 observed a resident dressed in extra layers, walking in a resident home area. The resident stated to Inspector #522 that they were cold.

Review of the home's Hot Weather Air Temperature Records for a two week period noted that on 13 out of 45 occasions, air temperatures had not been taken and recorded, as required.

Maintenance Staff (MS) #114 reviewed air temperature records with Inspector #522 and acknowledged that air temperatures were not taken daily. MS #114 stated if temperatures were not recorded on the Hot Weather Air Temperature record than they had not been taken.

Sources:
Review of the home's Hot Weather Air Temperature Records, the home's Air Temperature and Air Quality Control Policy #5-6-3 approved May 12, 2022, and interviews with a resident, MS #114 and other staff.

[522]

WRITTEN NOTIFICATION OBTAINING AND KEEPING DRUGS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 138. (1) (a) (ii).

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary

Inspector #522 observed an unlocked and unattended medication cart in the middle of the hallway outside a resident room. Residents were noted in the hallway.

Registered Practical Nurse (RPN) #112 acknowledged they had left the cart unlocked when they went into a resident's room and stated they should have locked the medication cart.

Sources:
Observations of medication carts on home areas, review of CareRx "Medication Administration Pass" policy revised August 15, 2018, and interviews with RPN # 112 and other staff.

[522]

WRITTEN NOTIFICATION MINIMIZING OF RESTRAINING

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 36 (3).

The licensee has failed to ensure that a Personal Assistance Services Device (PASD) used to assist a resident with a routine activity of living was included in the resident's plan of care.

Rationale and Summary

On two consecutive days, a resident was observed with a PASD in place.

Personal Support Worker (PSW) #106 stated the resident used the PASD.

Inspector #522 reviewed the resident's care plan with PSW #106. PSW #106 acknowledged the use of the PASD for the resident was not in the resident's plan of care.

Acting Director of Care (DOC) reviewed the resident's plan of care and acknowledged that the use of the PASD for the resident was not included in their plan of care and that staff should not use the PASD on the resident unless it was included in the resident's plan of care.

Sources: Observations of a resident, review of the resident's clinical record, the home's 'Personal Assistance Service Devices (PASDs)" policy # 3-5-18-05 reviewed June 2, 2022, and interviews with PSW #106, Acting DOC #100 and other staff.

[522]

WRITTEN NOTIFICATION RESIDENT RIGHTS

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

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

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's inherent dignity, was fully respected.

Rationale and Summary

A resident was observed in their room dressed inappropriately. The following day, the resident was observed outside the home area dining room dressed inappropriately.

PSW #125 stated that the resident had been dressed that way as they were waiting on an article of clothing for the resident.

Acting Director of Care (DOC) #100 stated it was inappropriate for staff to dress the resident that way, especially when the resident was going to the dining room.

Sources:
Observations of a resident, interviews with PSW #106, PSW #125 and Acting DOC #100.

[522]

WRITTEN NOTIFICATION TRAINING AND ORIENTATION

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 261 (1) 5.

The licensee has failed to ensure that all staff who applied physical devices or who monitored residents restrained by physical devices, received training in the application, use and potential dangers of these physical devices.

Rationale and Summary

FLTCA 2021 s. 82 (7) 4 states**,** every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.

O. Reg. 246/22 s. 261 (2) 1 states staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

On three occasions a resident was observed with a restraint in place which was not applied correctly.

Acting Director of Care (DOC) stated that staff received training on the application of restraints during orientation, but staff did not receive training on the application of restraints as part of the home's annual training on the minimizing of restraints.

Sources:

Interview with Acting DOC #100 and other staff.

[522]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Rationale and Summary

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes was issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021. The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19. LTCHS were to practice the health and safety requirements contained in the directive which included personal protective equipment (PPE) requirements.

A) Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes updated June 2022, states "When the screener is in-person, the screener should be behind a physical barrier, such as a polycarbonate sheet or keep a distance of two metres (6 feet). If this is not possible, the screener is required to wear personal protective equipment (PPE) per their personal risk assessment."

Review of the home's Pandemic Management policy noted screeners were to wear at minimum a mask, eye protection and gloves or screeners were to be behind a Plexiglas station or other barrier.

Inspectors were let into the vestibule entrance of the home by Screener #101 who was wearing a gown, mask, and glasses. Screener #101 was not wearing eye protection and there was no plexiglass barrier between Screener #101 and inspectors.

The following day, Resident Care Aide (RCA) #117 entered the vestibule while inspectors were completing Accushield screening. RCA #117 was wearing a mask, gown, and glasses. RCA #117 was not wearing eye protection and there was no plexiglass barrier in the vestibule. RCA #117 stated they were ensuring visitors completed the screening app and they did not wear any eye protection when they were inside the vestibule area with visitors.

Sources:
IPAC observations, review of the Prevention and Management of COVID-19 in Long-Term Care and Retirement Homes updated June 2022, the home's Pandemic Management policy #9-6-3 approved February 2, 2022, and interviews with RCC #117 and other staff.

[522]

B) Staff members #104 and #105 were observed with their mask below their chin sitting at their desks.

Housekeeper #132 was observed wearing a surgical mask and gloves loading garbage bags and dirty linen bags on to a utility cart. Housekeeper #132 was then observed pushing the utility cart down the hallway, while wearing the same pair of gloves used for loading the garbage bags and the dirty linen bags on to the cart.

Screener #108 was observed in the vestibule area of the home without eye protection. Two visitors were observed entering the vestibule together without a mask with Screener #108 present.

Screener #108 was observed performing a COVID-19 rapid test on a visitor without wearing gloves. Screener #108 then proceeded to perform another COVID-19 rapid test on another visitor, without gloves, and without performing hand hygiene.

Summer Student #116 was observed wearing their surgical mask below their mouth while cleaning high touch areas in the home.

The following day, Screener #117 was observed allowing a visitor to complete the Accushield screening and come into the home unmasked.

Screener #119 was observed performing COVID-19 rapid tests on visitors, without doffing their gloves and performing hand hygiene between tasks.

In an interview, Infection Prevention and Control (IPAC) Lead #102 stated that when screeners were performing COVID-19 rapid tests, they were expected to perform hand hygiene and wear appropriate Personal Protection Equipment (PPE), including eye protection and gloves.

IPAC Lead #102 stated that housekeepers were expected to doff their gloves after handling garbage and dirty linen bags and perform hand hygiene prior to touching the utility cart.

IPAC Lead #102 stated that staff were to wear a mask at all times, except for when eating or drinking in designated areas, while maintaining the physical distance of at least six feet.

IPAC Lead #102 stated that summer students were expected to wear a mask at all times while working in indoor or outdoor resident areas.

Public Health Inspector (PHI) #120 stated that screeners were expected to wear PPE including eye protection, unless they were in an area protected by a plexiglass shield. PHI #120 stated that screeners were to wear full PPE, including eye protection and gloves when performing COVID-19 rapid tests, then doff their gloves and perform hand hygiene prior to conducting next steps.

Sources: Observations of IPAC practices in the home, interviews with IPAC Lead #102, and PHI #120.

[733564]

COMPLIANCE ORDER [CO#001] MINIMIZING OF RESTRAINING

NC#012 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 119 (2) 6.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 119 (2) 6.

The Licensee must ensure:

A) A resident's condition is reassessed and the effectiveness of their restraint evaluated every eight hours, as required.
B) Registered Practical Nurse #123 receive retraining on the reassessment and evaluation of the effectiveness of specific restraints.
C) Maintain a record of the training provided including, but not limited to, date, time, attendee, trainer, and materials taught.

Grounds

Non-compliance with: O. Reg. 246/22 s. 119 (2) 6.

The licensee has failed to ensure that when a resident was restrained, the resident's condition was reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours, and at any other time, when necessary, based on the resident's condition or circumstances.

Rationale and Summary

Inspector #522 and Personal Support Worker (PSW) #125 observed a resident in their room with a restraint applied incorrectly.

The following day, Inspector #522 and Personal Support Worker (PSW) #106 observed the resident outside a home area dining room with a restraint applied incorrectly.

Review of the resident's electronic Medication Administration Record noted that registered staff were to reassess and evaluate the resident's restraint every eight hours.

Registered Practical Nurse (RPN) #123 was present at the entrance to the dining room, a few feet from the resident. Inspector #522 asked RPN #123 if they monitored the resident's restraint, each shift. RPN #123 stated they did not monitor the resident's restraint nor did they physically check the resident's restraint during their shifts.

Sources:

Observations of a resident, review of the resident's clinical record and interviews with PSW #106, PSW #125, RPN #123 and other staff.

[522]

This order must be complied with by September 30, 2022

COMPLIANCE ORDER [CO#002] MINIMIZING OF RESTRAINING

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 119 (1) 1.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 119 (1) 1.

The Licensee must ensure:

A) A specific resident's restraint is applied as per manufacturer's instructions.
B) All direct care staff assigned to a specific home area receive retraining on the application of a specific type of restraint.
C) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, and materials taught.

Grounds

Non-compliance with: O. Reg. 246/22 s. 119 (1) 1.

The licensee has failed to ensure that staff applied a resident's restraint in accordance with any manufacturer's instructions.

Rationale and Summary

Inspector #522 and Personal Support Worker (PSW) #125 observed a resident in their room with a restraint applied incorrectly.

The following day, Inspector #522 and Personal Support Worker (PSW) #106 observed the resident outside a home area dining room with a restraint applied incorrectly. PSW #106 was not aware that it was unsafe for the resident's restraint to be applied incorrectly.

Several days later, Inspector #733564 observed the resident's restraint with Registered Nurse (RN) #127. RN #127 checked the resident's restraint and confirmed that it was applied incorrectly.

Registered Practical Nurse (RPN) #124 stated the restraint should be applied correctly to the resident as if it was applied incorrectly, it could cause harm to the resident.

Sources:
Observations of a resident, review of the resident's clinical record, the manufacturer's instructions for the restraint, and interviews with PSW #106, PSW #125, RPN #123, RN #127 and other staff.

[522]

This order must be complied with by September 30, 2022

COMPLIANCE ORDER [CO#003] DUTY TO PROTECT

NC#013 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 24 (1).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021 s. 24 (1).

The Licensee must:

A) Retrain all registered staff, Personal Support Worker (PSW) #136, PSW #138, and PSW #139 on the home's prevention of abuse and neglect policy.
B) Educate all registered staff on the specifics of consent to treatment.
C) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, and materials taught.

Grounds

Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that a resident was protected from abuse by staff.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to staff to resident alleged abuse.

The CIS report stated that on a specific date, a staff member brought forward a complaint to the home which alleged a staff member had abused a resident, four days earlier.

The staff member indicated in the complaint that another staff member had performed a treatment on a resident without consent and the resident was fearful after the incident and had been in pain during the treatment. The staff member indicated in the complaint that they had observed the treatment and that the other staff member did not perform the treatment according to the order and that the actions of the other staff member were inappropriate.

A review of the home's "Prevention of Abuse and Neglect to Elders" policy stated, "Witnesses of any abuse of an Elder will immediately intervene and remove the Elder away from the situation and ensure they are safe."

A review of the resident's progress notes indicated that the resident had been upset several days after the treatment.

Sources: Review of the home's "Prevention of Abuse and Neglect to Elders" policy #2-8-18, dated August 15, 2017; a complaint letter from a staff member, a resident's progress notes, and interviews with staff members.

[733564]

This order must be complied with by September 30, 2022

COMPLIANCE ORDER [CO#004] REPORTING CERTAIN MATTERS TO DIRECTOR

NC#015 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 28 (1) (2).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021 s. 28 (1) (2).

The Licensee must:

A) Retrain Personal Support Worker (PSW) #136, PSW #138, and PSW #139 on mandatory reporting of abuse.
B) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainer, and materials taught.

Grounds

Non-compliance with: FLTCA, 2021 s. 28 (1)(2)

The licensee has failed to ensure that a person who had reasonable grounds to suspect the abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to staff to resident alleged abuse.

The CIS report stated that on a specific date, a staff member brought forward a complaint to the home which alleged a staff member had abused a resident, four days earlier.

The Ontario Regulations 246/22 defines “abuse”, in relation to a resident, as physical, sexual, emotional, verbal or financial abuse, as defined in the regulations in each case; (“mauvais traitements”).

During an interview, the staff member stated that they did not report the alleged abuse that occurred, immediately to the Director of Care.

During an interview, Interim Director of Care #100 stated that the home’s expectation was that the alleged abuse should have been reported immediately to the Director.

Sources: Review of a CIS report; interview with a staff member and Interim Director of Care #100.

[733564]

This order must be complied with by September 30, 2022

COMPLIANCE ORDER [CO#005] POLICE NOTIFICATION

NC#016 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 105.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 105.

The Licensee must:

A) Educate General Manager #122, and Interim Director of Care #100, on duty to report alleged, suspected or witnessed incidents of abuse or neglect of a resident that may constitute a criminal offence to the Police.
B) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainer, and materials taught.

Grounds

Non-compliance with: O. Reg. 246/22 s. 105

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Rationale and Summary

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care related to staff to resident alleged abuse.

The CIS report stated that on a specific date, a staff member brought forward a complaint to the home which alleged a staff member had abused a resident, four days earlier.

The staff member indicated in the complaint that another staff member had performed a treatment on a resident without consent and the resident was fearful after the incident and had been in pain during the treatment. The staff member indicated in the complaint that they had

observed the treatment and that the other staff member did not perform the treatment according to the order and that the actions of the other staff member were inappropriate.

A review of the resident's progress notes indicated that the resident had been upset several days after the treatment.

During an interview, Interim Director of Care #100 stated that police were not notified and acknowledged that the police should have been notified immediately of the alleged abuse.

Sources: Review of a CIS report; and interview with Interim Director of Care #100.

[733564]

This order must be complied with by September 30, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.

- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.