Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

# Public Report

**Report Issue Date:** January 13, 2025

**Inspection Number:** 2025-1227-0001

**Inspection Type:**
Critical Incident
Follow up

**Licensee:** Medlaw Corporation Limited

**Long Term Care Home and City:** Pinecrest Nursing Home (Bobcaygeon), Bobcaygeon

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6 - 10, 13, 2025

The following intake(s) were inspected:

- Intake: #00125005 - regarding alleged sexual abuse of resident by a resident.
- Intake: #00129448 - regarding a fall of resident resulting in fracture.
- Intake: #00129618 - Follow-up #1 - Compliance Order (CO) #001 - FLTCA, 2021 - s. 19 (2) (c) -Accommodation services. Compliance due date (CDD): January 13, 2025.
- Intake: #00129619 - Follow-up #1 -CO #004 - FLTCA, 2021 - s. 28 (1) 2. - Reporting certain matters to Director. CDD: November 29, 2024.
- Intake: #00129620 - Follow-up #1 -CO #002 - FLTCA, 2021 - s. 27 (1) (a) (i) - Licensee must investigate, respond and act. CDD: November 29, 2024.
- Intake: #00129621 - Follow-up #1 -CO #003 - FLTCA, 2021 - s. 27 (1) (b) - Licensee must investigate, respond and act. CDD: November 29, 2024
- Intake: #00129622 - Follow-up #1 -CO #005 - O. Reg. 246/22 - s. 24 (1) - Air temperature. CDD: November 29, 2024.
- Intake: #00135312 - Follow-up #2 -CO #001 / 2024-1227-0001, - O. Reg. 246/22, s. 102 (2) (b), original CDD August 12, 2024, Reinspection Fee: $500.00.

The following intake was completed in this inspection:

- Intake: #00124842 - regarding a fall of resident resulting in a fracture.

## Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1227-0002 related to FLTCA, 2021, s. 19 (2) (c)
Order #004 from Inspection #2024-1227-0002 related to FLTCA, 2021, s. 28 (1) 2.
Order #002 from Inspection #2024-1227-0002 related to FLTCA, 2021, s. 27 (1) (a) (i)
Order #003 from Inspection #2024-1227-0002 related to FLTCA, 2021, s. 27 (1) (b)
Order #005 from Inspection #2024-1227-0002 related to O. Reg. 246/22, s. 24 (1)
Order #001 from Inspection #2024-1227-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Housekeeping, Laundry and Maintenance Services
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Right to quality care and self-determination

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.**
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure a resident's personal health information was kept confidential.

The electronic medication administration tablet screen was observed unlocked and displaying personal health information (PHI) pertaining to a resident. The personal health information was visible to residents and others in a south residential hallway of the long-term care home.

**Sources:** Observations; and an interview with a Registered Nurse.

## WRITTEN NOTIFICATION: Plan of Care

NC #002 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; and

1. The licensee failed to ensure that direct care staff were provided clear direction related to the care of a resident. The resident was identified to be at risk for falls. The plan of care failed to identify clear direction to staff related to activities of daily living, specifically assistance required for dressing, mobility, transfers and toileting.

**Sources:** Clinical health record for a resident; and an interview with Registered Practical Nurse (RPN).

2. The licensee failed to ensure that the written plans of care for a residents and co-resident provided clear directions to staff and others who provide direct care.
A Critical Incident Report (CIR) was submitted to the Director, which reported alleged sexual abuse by a resident towards a resident. Reviewing the written plans of care for both residents, it was found that there were no clear directions for staff on how to prevent occurrence and safety of the resident. Prior to this alleged sexual abuse incident reported to the Director; the resident had several similar incidents with co-residents.

**Sources:** Critical Incident Report, residents clinical health records, BSO_6_Sexual Behaviour policy, interview with the Behaviourial Support Lead.

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 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 failed to ensure the care set out in the plan of care was provided to a resident.

A resident was identified as being at 'high' risk for falls and required the assistance of staff for activities of daily living. The plan of care indicated that Fall Prevention and Management interventions for the resident had been developed and included, the resident was to ambulate with a walker, and was to wear non-slip socks. Documentation identified the resident fell and sustained a fracture. Documentation identified the resident not having the fall prevention equipment as described in the plan of care at the time of the fall.

**Sources:** Clinical health record for the resident, Critical Incident Report; and an interview with a RN, and the Director of Care.

## WRITTEN NOTIFICATION: When reassessment revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (10) (c)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that a resident was reassessed, and that the plan of care was revised when the plan was not effective.

The clinical health record for a resident identified the resident was assessed as being at a high' falls risk. Documentation identified the resident fell numerous times during a 6-month period. Documentation failed to identify that Fall Prevention and Management strategies had been revised when the plan had not been effective following each of the fall incidents. Resident's tenth fall, resulted in the resident sustaining injury, specifically a fracture, and resulted in a significant change in their health condition.

**Sources**: Clinical health record for the resident, Critical Incident Report; and an interview with an RPN.

## WRITTEN NOTIFICATION: Reassessment, revision

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (11) (b)**
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee failed to ensure that different approaches to care were considered when the plan of care was not effective.

The clinical health record for a resident identified the resident was assessed as being at risk for falls. Interventions developed and implemented related to fall prevention included, staff to remind resident to use their mobility device, bed alarm, and that the call bell was to be attached to resident's clothing. Documentation identified that the resident fell numerous times in the last year, all falls resulted in

head injury routine being initiated and two of the incidents resulted in the resident sustaining injury. Registered nursing staff and the Director of Care (DOC) indicated that the resident was known to forget to use their mobility device, turn off the bed alarm, and was known to remove the call bell from their clothing. Documentation reviewed and interviews with staff and managers failed to identify that different approaches had been considered when planned interventions were not effective.

**Sources**: Clinical health record for the resident, Critical Incident Report; and interviews with Registered Practical Nurse, Registered Nurse and the DOC.

## WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)**
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee was immediately investigated.

A Critical Incident Report was submitted to the Director regarding an alleged sexual abuse incident involving a resident towards co- resident.

During a record review, it was documented in the risk management system that resident had several incidents of inappropriate sexual behaviour prior to the incident

report to the Director. These incidents were not investigated.

**Sources:** Critical Incident Report, resident clinical records, Policy: BSO 6 - Sexual Behaviours, interview with the Administrator/ Acting Behavioural Support Ontario Lead.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that any person with reasonable grounds to suspect that sexual abuse has occurred or may occur immediately reports the suspicion to the Director.

A Critical Incident Report (CIR) was submitted to the Director, alleging sexual abuse by a resident towards a resident. During a clinical health review, the resident, indications of similar inappropriate sexual behaviour involving two different co-residents were noted. These incidents were not reported to the Director.

**Sources**: Critical Incident Report, a resident clinical health records, Policy: BSO 6 – Sexual Behaviours, and interview with the Administrator / acting Behavioural Support Ontario.

## WRITTEN NOTIFICATION: Communication and response system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 20 (a)**
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure the resident-staff communication and response system (RSCRS) could be accessed and used by residents. A resident was observed seated in a wheelchair and without the RSCRS within their reach. The resident is dependent on staff for their care needs, and at risk for falls.

**Sources:** Observations; and clinical health record for a resident.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure their Falls Prevention and Management Program was complied with, specifically related to the monitoring of a resident.

Pursuant to O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure written policies developed for the Falls Prevention and Management program were complied with.

The clinical health record for the resident  failed to identify the resident was monitored at minimum on every shift, for seventy-two hours following fall incidents, as indicated by the licensee's policy.

**Sources:** Clinical health record for resident, licensee policy 'Fall Prevention and Management Program'.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (2)**
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident had fallen that a post fall assessment was conducted using a clinically appropriate instrument. The resident fell several times during a six-month period. Documentation failed to identify that a post-fall assessment tool was completed following each incident.

**Sources:** Clinical health record for the resident.

## WRITTEN NOTIFICATION: Skin and wound care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

1.The licensee failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly.

A resident was assessed by a Registered Nurse (RN) to have altered skin integrity. The clinical health record failed to identify that the resident was reassessed weekly, following this assessment.

**Sources:** Clinical health record for a resident.

2.The licensee failed to ensure that a resident who was exhibiting altered skin integrity was reassessed at least weekly.

A resident fell, sustained injury, and was assessed as having a skin tear and bruising resulting from the fall incident. Documentation failed to identify that the altered skin integrity was reassessed at least weekly.

**Sources:** Clinical health record for a resident.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure a resident demonstrating unmanaged sexual responsive behaviours took actions to respond to the needs of the resident, including assessments, reassessments and interventions.

Critical Incident Report (CIR) was submitted to the Director regarding a sexual abuse incident involving a resident towards a co -resident. During a clinical record review, the resident had several inappropriate sexual behaviours.

A resident's inappropriate sexual behaviour focus on their plan of care was initiated 3 years ago and there were no revision made when the interventions were ineffective. There were no revisions in the resident plan of care after the Critical Incident Report was submitted to the Director.

**Sources:** Critical Incident Report, a resident record review, interview with the acting Behavioural Supports Ontario lead/ Administrator.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1.The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented. The IPAC Standard required under section 9.1, (f) directs at minimum, Additional Precautions must include appropriate selection application, removal, and disposal of personal protective equipment (PPE).

The long-term care home was identified, by Public Health, to be in an enteric outbreak, which required enhanced IPAC control measures to be taken. A Personal Support Worker (PSW) was observed donning PPE prior to entering a resident room, which was identified as being under enhanced control measures, specifically 'Droplet-Contact' precautions. Observations failed to identify that the PSW performed hand hygiene following the removal of their procedural mask, and prior to applying their N95 mask and eye protection.

**Sources:** Observations; clinical health record for the resident, licensee's line listing for declared outbreak; and an interview with IPAC Lead-Registered Nurse.

2.The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented. The IPAC Standard required under section 9.1, (e) directs at minimum, Additional Precautions must include, point-of-care signage indicating that enhanced IPAC control measures are in place.

The long-term care home was declared by Public Health to be in an enteric outbreak. Residents residing in two different rooms were identified as cases in the outbreak. Observations failed to identify that point-of-care signage, specifically 'Droplet-Contact' indicating enhanced control measures were in place.

**Sources:** Observations; review of the clinical health record for residents, licensee's line listing for declared outbreak; and an interview with IPAC Lead-Registered Nurse.

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)**
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure drugs were stored in a medication cart that was secured and locked.

Resident prescribed medications, specifically Acetaminophen, Apixaban and three other unidentified medications, were observed on top of an unattended medication cart in a residential hallway. A Registered Nurse (RN), who was assigned to the medication cart, was inside a resident's room with the door closed. Residents were observed in the vicinity of the medication cart.

**Sources**: Observations; and an interview with RN.

## COMPLIANCE ORDER CO #001 Duty to protect

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

1. Ensure residents involved in the incident are protected from abuse and neglect, including sexual abuse.

a) Immediately implement clear direction for staff and interventions to protect residents and any other residents at risk from abuse, including sexual abuse.

These interventions will remain in place while the licensee develops, implements, and assesses successful strategies for the mentioned residents.
Ensure the written care plans for these residents are immediately updated with clear instructions on managing and minimizing risks to all residents. Document the date, specific interventions, and clear directions initiated. The documentation must include details of the interdisciplinary team, the residents, and their substitute decision-makers involved in implementing the interventions, as well as how this information is communicated to all staff.

b) Initiate a behaviourial support assessment, including a My Personhood Summary for these residents. Keep record of assessments, and dates of assessments and who participated in the assessments.

c) The BSO lead or designate will meet weekly with the assigned Personal Support Worker (PSW) and the assigned registered staff to discuss these resident's plan of care, including any responsive behaviours for eight weeks. Keep a documented record of the name of the PSW and registered staff, the date of the meeting, what responsive behaviours these residents had that week.

If the resident had responsive behaviours that week, the BSO lead, PSW and registered staff will implement interventions to manage the resident's responsive behaviours. The following week at the meeting, the BSO lead will document the resident's response to those interventions. If the interventions implemented were not successful, the BSO lead will document what other interventions were implemented, as well as what assessments or reassessments will be completed, and what referrals if any have been made. If the resident's responsive behaviours are managed and no behaviours occurred that week indicate this on the documentation. Provide all documentation upon request of the Inspector.

d) The BSO lead or designate will update these residents care plan /plan of care with the new interventions ongoing. Provide a record of the updated care plan/plan of care with the changes over the eight weeks upon request of the Inspector. The licensee will maintain an ongoing documentation of successful and unsuccessful interventions and the reason why it was or wasn't successful.

e) During the eight-week period the BSO lead or designate will communicate to staff any new interventions implemented for these residents. Keep a documented record of what was communicated to staff, the platform used and the dates the communication occurred. Provide the documentation upon request of the Inspector.

2) The licensee will request an external resource or support to provide education to the long-term care home. The education will include what constitutes as sexual abuse in long-term care home, how the staff are to assess and confirm consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person. The education will include the possible reasons or unmet needs a resident may be expressing. This education will be provided to all registered staff, including agency staff.

Keep documentation of the education material, who provided the education, date and time education was provided. Keep a record of staff trained and signatures

confirming their attendance.

**Grounds**

The licensee failed to protect residents from sexual abuse by a resident.
A Critical Incident Report (CIR) was submitted to the Director, regarding alleged sexual abuse towards a resident. Clinical records from the last two years indicated that the resident had many incidents of inappropriate sexual behavior before notifying the Director. The co-residents had experienced repeated inappropriate sexual behaviours towards them.

The alleged abuser's written plan of care for inappropriate sexual behaviours, initiated several years ago. However, there were no further documented actions when ongoing incidents occurred. Including the actions taken to address the resident's potential unmet needs, including assessments, reassessments, and interventions, nor were the resident's responses to interventions documented. There were no revisions made to the resident's plan of care for the last 3 years.

The plans of care for co- residents did not indicate that they were at risk of inappropriate sexual behaviour from the resident, and it was unclear how the home was protecting these co- residents specifically from the resident. The acting BSO Lead mentioned that co- resident would be brought to their room if there was no direct supervision, limiting the resident to common areas depending on staff levels. The licensee failed to protect co- residents by not addressing and managing the resident's sexually inappropriate behaviour effectively.

The following non-compliance was identified within this report specific to the resident's inappropriate sexual behaviour:

- Written Notification, FLTCA, 2021 s. 6 (1) (c)
- Written Notification, O. Reg 246/ 22 s. 58 (4) (c)

- Written Notification, FLTCA, 2021 s. 28 (1) 2.
- Written Notification, FLTCA, 2021 s. 27 (1) (a) (i)

By failing to ensure a resident sexual  behaviours were reported, investigated and attempted to manage, lead to ongoing suspected sexual abuse towards co-residents.

**Sources:** Critical Incident Report, clinical health records of residents, Policy: BSO_6_Sexual Behaviour, and interview with the acting Behaviourial Supports Ontario (BSO) Lead.

**This order must be complied with by** April 4, 2025

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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.