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

North District
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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: March 14, 2023

Inspection Number: 2023-1575-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The District of the Municipality of Muskoka

Long Term Care Home and City: The Pines, Bracebridge

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2023.03.24 08:10:40 -04'00'

Additional Inspector(s)
Charlotte Scott (000695) attended this inspection during orientation.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 9-13, 2023.

The following intake(s) were inspected:
- one intake regarding a resident fall that resulted in a significant change in status;
- one intake regarding a complaint related to the management of responsive behaviours; and,
- two intakes regarding an allegation of staff to resident physical abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SDM notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that that the resident's Substitute Decision Maker (SDM) was notified immediately of allegations of physical abuse that resulted in pain or injury to the resident, or caused distress to the resident that could have been potentially detrimental to the resident's health or wellbeing.

Summary and Grounds
The Administrator and Director of Care (DOC) became aware of an allegation of staff to resident abuse, however, the Critical Incident (CI) Report indicated that the SDM of the resident was notified several hours after the management team was aware of the incident.

The Administrator indicated that the SDM should have been notified immediately when the home became aware.

Sources: The CI report; the resident's progress notes; internal investigation notes; licensee policy " Notifying SDM", RC-09-01-03; and, interview with Administrator.

[736]

WRITTEN NOTIFICATION: Reporting to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

1) The licensee has failed to ensure that when there was an allegation of resident abuse, the allegation and the grounds on which it was based on, was immediately reported to the Director.

Summary and Grounds
A resident was noted to be displaying specific responsive behaviours towards another resident.

There was no CI report submitted for an allegation of resident abuse.

The DOC indicated that based on the progress notes, the home had reasonable grounds to suspect that the resident abuse may have occurred, and that the home should have immediately reported the allegations to the Director.

There was minimal harm from the allegation of resident to resident abuse not being reported to the Director.

Sources: Long-Term Care Homes Portal; residents' progress notes and care plan; licensee policy titled "Zero tolerance of Resident Abuse and Neglect: response and reporting", RC-02-01-02; last reviewed January 2022; and, interview with the DOC and other staff.

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2) The licensee has failed to ensure that an allegation of staff to resident abuse was immediately reported to the Director.

Summary and Grounds
An allegation of abuse involving a resident and staff was brought forward after the incident had taken place, to the RN. The RN who became aware of the incident, did not immediately report the allegations of abuse to the Director, or a member of the nursing management team at the home.

The Administrator became aware of the allegations of abuse the following day.

The allegation of staff to resident abuse was not reported to the Director until the day after the incident took place.

The Administrator acknowledged that the allegation of staff to resident abuse should have been immediately reported to the Director, and was not.

There was minimum risk of harm to the resident from the incident not being immediately reported to the Director.

Sources: The CI report; internal investigation notes; licensee policy titled “Zero Tolerance of Abuse and Neglect: Response and Reporting”, RC-02-01-02, last reviewed January 2022; and, interview with Administrator and other staff.

[736]

WRITTEN NOTIFICATION: No Falls Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home.

Summary and Grounds
The licensee policy titled "Falls Prevention and Management Program", RC-15-01-01, last reviewed January 2022, indicated that the home was to have implemented a comprehensive program to prevent and reduce the incident and severity of falls; as well, that the home was to designate one or more Falls Program Leads to act as the clinical champion, and coordinate key aspects of the program, including tracking process against goals.

In separate interviews with the DOC and Administrator, they both indicated that the home did not currently have any "core" programs functioning, including the home did not have a comprehensive falls program implemented in the home, and the home did not have a designated lead at the time of inspection for the Falls Program.

There was moderate risk to all residents who were at risk for falls, by the home not having implemented a falls prevention and management program in the home.

Sources: licensee policy titled "Falls Prevention and Management Program", RC-15-01-01, last reviewed January 2022; and interviews with the DOC and Administrator.

[736]

WRITTEN NOTIFICATION: No Pain Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 4.

The licensee has failed to ensure that a pain management program to identify pain in residents and manage pain were developed and implemented in the home.

Summary and Grounds
The DOC and Administrator both indicated that the home did not have "core" programs running at the time of inspection, including that the home did not have an implemented pain management program, and there was no lead for the program.

Sources: interview with the DOC, and Administrator.

[736]

WRITTEN NOTIFICATION: Pain Policy

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, and the licensee's pain policy was complied with.

Summary and Grounds
O. Reg 246/22, 11 (1) (b) requires the license of a long term care home to have a policy, and program in place to manage a resident's pain, and ensure that the policy and program is complied with.

Progress notes indicated that the resident had expressed pain. Documentation indicated that no as needed "PRN" medication was available, and that staff would inform the physician the next day. Progress notes through the night indicated that resident continued to express discomfort, and that no PRN was available.

There was no pain assessment completed on the resident, and no reassessment completed either.

The home's pain policy, titled "Pain Identification and Management", RC-19-01-01, reviewed January 2022, indicated that if a resident had a new onset of acute pain, the physician or NP was to be contacted immediately.

The DOC confirmed that based on the progress notes, and assessments of the resident, they were not assessed or reassessed appropriately, and that, as per the home's pain management policy, the physician should have been made aware, and a PRN order for pain medication obtained.

There was actual harm to the resident, as they remained in pain until the next day.

Sources: The resident's progress notes, electronic medication administration record (eMAR) and assessments; licensee policy titled "Pain Identification and Management", RC-19-01-01, last reviewed January 2022; and, interview with DOC.

[736]

WRITTEN NOTIFICATION: Bindings on License

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

1) The licensee has failed to ensure that there was a policy in place for individuals who had a medical condition that inhibited their ability to wear a mask, as per the guidance set out in the COVID-19 guidance document for Long Term Care Homes in Ontario.

Summary and Grounds
The Inspectors observed a staff member in the screening area of the home, completing active screening for staff and visitors. A staff member was not wearing the required personal protective equipment, as set out in the guidance set out in the COVID-19 guidance document for Long Term Care Homes in Ontario.

The Inspector requested to see a copy of the home's policy related to individuals who were unable to wear a medical mask.

The Inspector spoke with the Infection Prevention and Control (IPAC) lead, who indicated that the home had not yet developed a policy for individuals who were unable to wear a mask due to a medical condition, despite knowing it was a requirement.

Sources: Inspector observations; licensee IPAC policies; and interview with the IPAC lead, screener, Public Health Inspector, and other relevant staff.

[736]

2) The licensee has failed to ensure that the operational or policy directive that applied to the Long-

Term Care Home (LTCH), related to PPE requirements for suspected or confirmed cases of COVID-19, was complied with.

Summary and Grounds
In accordance with the Minister's Directive: COVID-19 response measures for LTCHs, effective August 30, 2022, identified that homes must ensure the PPE requirements as set out in the "COVID-19 Guidance: LTCHs and Retirement Homes (RHs) for Public Health Units (PHUs)", or as amended, were followed. The Ministry of Health COVID-19 Guidance Document: LTCHs, effective October 6, 2022, identified that all staff providing direct care to or interacting with a suspect or confirmed case of COVID-19, should wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator.

a) The Inspector noted that a staff member was in a resident room, with the resident, that was identified as a contract/droplet precaution room, in the COVID-19 outbreak area. The staff member had no gown, gloves or eye protection on, and the Inspector noted that the mask the staff member was wearing appeared to have a design on it.

The staff member exited the room, and identified themselves, and further indicated that they were wearing a non fitted mask.

The IPAC lead identified that staff were to wear a fit-tested N95 respirator when on the COVID-19 outbreak unit.

b) The Inspector noted a staff member in a room with a resident on the COVID-19 outbreak area, that was labelled "Contact/Droplet" precautions, and the staff member was not utilizing gown, gloves or face protection.

c) The Inspector observed multiple staff on the COVID-19 outbreak home area without eye protection on, despite signage at the entrance and the eye protection being available. Numerous residents were noted to be wandering throughout the home area, and redirection being required by staff.

d) The Inspector observed staff members exiting the COVID-19 outbreak home area, into other areas of the home without removing their eye protection or their face masks, despite the rest of the home areas not being in a COVID-19 outbreak.

The IPAC lead indicated that based on the Inspector's observations, the home's IPAC policies that were in line with the guidance documents, were not being complied with, and should have been

Sources: Inspector observations: licensee policy titled "COVID 19 Universal PPE Guidelines, IC-05-01-13,

Last reviewed November, 2022, appendix 1"; and interviews the RN, IPAC lead, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Hand Hygiene

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed ensure that the IPAC standard issued by the Director was implemented and complied with, related to supporting residents with hand hygiene prior to meal service.

Summary and Grounds
The IPAC standard issued by the Director required the licensee to implement a hand hygiene program to ensure that residents were encouraged and/or assisted with hand hygiene prior to meal service.

The Inspector observed that the residents were not encouraged or assisted with hand hygiene prior to meal service.

The IPAC lead indicated that all residents should be offered hand hygiene prior to meal service by staff.

Sources: Inspector observations of the meal service; licensee policy titled "Hand Hygiene", IP-02-01-08, last reviewed April 2022; and, interview with IPAC lead.

[736]

WRITTEN NOTIFICATION: Preventing Altercations

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that interventions were implemented for the resident, to minimize potentially harmful interactions between the resident, and other residents on the home area.

Summary and Grounds
The resident was known to target specific co-residents with responsive behaviours based on staff observations and progress notes. The resident's plan of care did not indicate to staff that the resident

was known to display responsive behaviors towards specific co-residents.

The DOC indicated that the resident's care plan should have included further details, such as interventions to minimize potentially harmful interactions between the resident and other residents.

Sources: The resident's progress notes and care plan; and interview with the DOC, and other relevant staff.

[736]

WRITTEN NOTIFICATION: Reporting to the Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was notified within one business day of the resident sustaining an injury that the resident was taken to hospital for, and that resulted in a significant change in the resident's health condition.

Summary and Grounds
Progress notes for the resident indicated that the resident had sustained an injury, and that the resident was transferred to hospital. Progress notes indicated that the home had followed up with the hospital prior to the resident's return. The CI report was not reported until the resident returned from the hospital.

Both the DOC and Administrator indicated that the CI report should have been reported earlier than when the resident returned from hospital.

Sources: The CI report; the resident's progress notes; and, interview with DOC and Administrator.

[736]

WRITTEN NOTIFICATION: Collaboration for Plan of Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other for the resident.

Summary and Grounds
The resident's progress notes initially indicated that the resident was non weight bearing, but used an assistive device for transfers. Approximately a month later, documentation indicated that the resident was able to weight bear as tolerated.

Nursing assessments and the care plan indicated that the resident was non weight bearing, had no mention of an assistive device being used, and there was no lift and transfer assessment completed.

The DOC reviewed the resident's care plan, progress notes, and assessments and indicated that those involved did not ensure that their assessments were collaborative, so that the assessment would be consistent with and compliment each other, and that the plan of care was not developed so that different aspects were integrated and consistent with and complemented the care needs for the resident.

Sources: The resident's care plan, progress notes and assessments; interview with the DOC, as well as other staff.

[736]

WRITTEN NOTIFICATION: Falls Policy not Complied

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the program in place to manage fall prevention for the resident.

In accordance with O.Reg 246/22 s. 11 (1) b, the licensee was required to ensure that there was a falls program in place and that the policies in the falls program were complied with.

Summary and Grounds
Specifically, staff did not comply with the policy “Falls Prevention and Management Program”, dated

January 2022, which was included in the licensee's Falls Prevention and Management Program.

Staff did not complete a required assessment of the resident after a significant change in status, or quarterly. The resident had not had the assessment completed since admission, despite having sustained significant changes in status.

The DOC indicated that staff were to complete the assessment for residents after a significant change in status, as part of the home's fall prevention and management program. The DOC reviewed the resident's assessments, and confirmed that despite having significant changes in status, the resident had not the required assessment completed since admission.

Sources: The resident's progress notes, and assessments; licensee policy titled "Fall Prevention and Management Program", last reviewed January 2022; interview with DOC, and other staff.
[736]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #012 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

a) Conduct weekly multidisciplinary care conferences for the resident, which include staff who provide direct care to the resident, to review the interventions in place, their effectiveness, and if any other interventions need to be trialed. Maintain detailed records of the care conferences, including who attended, the date and time of the meeting, the suggestions were discussed, and action taken following the conference;
b) Complete an audit ongoing weekly of the interventions that are in the plan of care for the resident, to ensure that they are implemented, for at least one month after the compliance due date, and until for a period of four weeks that there is no concerns noted. If any concerns are identified during the audits, implement and document corrective action to address the concern; and,
c) Develop and implement an educational plans for all staff, including managers, related to the recognition and reporting of potential abuse of residents.

Grounds
1) The licensee has failed to ensure that the resident was protected from abuse from PSWs.

Summary and Grounds

O. Reg 246/22, s. 2 (1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

There was a founded incident of staff to resident abuse, that was witnessed by another staff member. The staff member had expressed that they were not comfortable with the situation, however, did not intervene, and did not call for additional assistance.

The resident was noted to have injuries as a result of the incident.

It was also determined that one of the staff members involved had not completed their annual prevention of resident abuse training at the time of the incident.

The Administrator indicated that the home had not protected the resident from abuse by the staff members.

Sources: The CI report; internal investigation notes; the resident's progress notes; staff education records for 2021, and 2022; licensee policy titled “Zero Tolerance of Resident Abuse and Neglect Program”, RC-02-01-01, last reviewed January 2022; interview with Administrator, and other staff.

[736]

2) The licensee has failed to ensure that residents were protected from abuse by another resident.

Summary and Grounds
a) On September 6, 2022, the licensee was issued a written notice for Duty to Protect of a resident from abuse from another resident.

A review of the residents' progress notes indicated that the resident was seen exiting and entering the other resident's room on separate occasions, including after the September report was served to the home; requiring staff to redirect the resident.

b) Interventions that were in place in the resident's plan of care were noted not to be implemented at all times, and the resident was found again in the other resident's room.

During the inspection, it was noted that the resident's plan of care did not specify that the resident displayed responsive behaviours towards other residents in the home.

The DOC indicated that based on the progress notes in the resident charts, residents were not protected

from abuse by the resident, and should have been.

c) The resident was noted to be displaying responsive behaviours towards co-residents on the home area.

The resident's plan of care was not reviewed and revised again until external resources provided suggestions some time later. Despite the interventions in place, the resident continued to attempt to enter the co-resident's room, and at the time of inspection, the plan of care had not been reviewed or revised, despite being ineffective.

The DOC indicated that the resident being found in the co-resident rooms ongoing demonstrated that the plan of care was not effective, and the plan of care should have been reviewed and revised to have further interventions to prevent the resident from displaying behaviours towards co-residents.

d) The resident's plan of care identified strategies to manage the resident's responsive behaviours.

During the inspection, the Inspector did not observe the strategies in place for the resident, that were identified in the plan of care.

In an interview with the RPN, they indicated that they were not aware of specific interventions that were supposed to be in place for the resident, and also indicated that the discussed interventions were not realistic for the staff to implement.

Sources: The resident's care plan, and progress notes, as well as BSO notes; co-resident's progress notes; Inspector observations, and, interview with the RPN, DOC, Administrator, and other staff.

This order must be complied with by April 21, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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:

The licensee has a previous compliance history, with a CO issued on August 25, 2022, under report #2020_615759_0016 for s. 19, Duty to Protect.

This is the second time the licensee has failed 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 #002 Plan of Care not Revised

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Designate a falls lead for the program. Provide the Falls Lead with education related to the Falls Management Program and Policies, and keep record of the education, including who provided the education, the date(s) the education was provided, and what was covered;
2) Develop and keep record of an internal audit process to ensure that the Falls Lead is following the home's Falls Program, and what actions are taken if deficiencies are noted. Continue the audit for at least one month past the Compliance Due date,
3) Conduct and document a multidisciplinary care review for the resident's plan of care to ensure that it is accurate, including a focus on toileting, transferring, fall prevention measures, and assistive devices. Keep a record of the date of the multidisciplinary care review, who attended, and what changes were suggested and/or made.
4) Develop and sustain a process to ensure that the resident's plan of care is kept current and up to date; reviewing weekly for a period of four weeks with the multidisciplinary team, or longer if concerns are identified,

5) Provide training to all staff who are responsible for plan of care updating related to their roles and responsibilities, how and when to update the plan of care, and keep record of the training.

Grounds
The licensee has failed to ensure that when the care set out in the resident's plan of care was not effective, required, or the goals had been met, the plan of care was reviewed and revised.

Summary and Grounds
The resident sustained a number of falls during a specific period of time. During that time, the only change to the plan of care was to resolve interventions related to falls prevention management, which were all still required interventions in the plan of care for falls prevention management for the resident.

The resident sustained an injury that resulted in a significant change in status, however, no new interventions were added to the resident's plan of care at that time for fall prevention management.

The resident sustained further falls, that resulted in another injury, with a second significant change in status.

There were no new interventions added to the resident's plan of care until the resident returned to the long term care home after the second significant change in status.

Since the resident's return from hospital, the resident has sustained a number of further falls, some with injury, however there have been no further reviewed or revised interventions added related to their falls prevention management strategies.

The DOC reviewed the resident's falls history, and the plan of care, and indicated that based on the dates in the plan of care, and what was resolved, the resident's plan of care was not reviewed and revised when not effective, and should have been.

b) Upon observation, it was noted that the resident was in an assistive device with a therapeutic surface.

The PSW and RN indicated that the resident required an assistive device with a therapeutic surface.

The resident’s plan of care did not set out that the resident required the assistive device or therapeutic surface.

The Resident Assessment Instrument (RAI) Coordinator and DOC reviewed the resident’s plan of care and confirmed that the plan of care for the resident had not been revised to include the interventions.

c) The resident's care plan directed staff on how to transfer the resident, and what their toileting needs were. The PSW indicated that the resident's needs for transferring and toileting were different than what was listed in the resident's plan of care directions.

d) Progress notes indicated that the resident had been reviewed by the medical team, and the resident's ability to transfer was changed; however, at the time of inspection, the resident's care plan still indicated that the resident required additional transferring assistance.

In an interview with the physiotherapist, they indicated that based on the medical team assessment, the resident was able to participate further in the transfer process.

The DOC reviewed the resident's plan of care and indicated that the resident no longer had some interventions in place, and that and that the plan of care had not been reviewed and revised.

Sources: The resident's care plan, progress notes and assessments; interview with the DOC, and other staff.

[736]

This order must be complied with by April 21, 2023

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.