Ontario

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

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

Ottawa District
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Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 2, 2025

Inspection Number: 2024-1011-0005

Inspection Type:
Proactive Compliance Inspection

Licensee: 2629693 Ontario Inc.

Long Term Care Home and City: Sarsfield Colonial Home, Sarsfield

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26- 29, 2024 and December 2, 3, 5, 6, 9-13, 2024.

The following intake(s) were inspected:

- Intake: #00132747 - PCI

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect

Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

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)
Non-compliance with: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

Non-Compliance was found during this inspection on November 29, 2024 for failure to post the mandatory Whistleblowing Protection Policy, 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 FLTCA, 2021, section 85 (3) (r) related to section 30 of the Act and required no further action.

Date remedy was implemented was December 5, 2024.

Sources: Observations, interview with the administrative assistant.

WRITTEN NOTIFICATION: Restraints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.
Requirements relating to restraining by a physical device

s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee has failed to ensure that all restraint assessments, reassessments and monitoring and resident responses, for a resident were documented.
A resident was observed using assistive devices. The Director of Care (DOC) acknowledged and confirmed to the inspector that no reassessments on the resident's assistive devices and their effectiveness were completed by the registered staff or physician.

Sources: Observation, resident's medical chart; interview with DOC .

WRITTEN NOTIFICATION: Personal assistance service device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 3.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

1. The licensee has failed to ensure that the use of the Personal assistance service device (PASD) has been approved by a person provided for in the regulations.

The use of an assistive device under subsection (3) to assist a resident with specific activities should have been included in the resident's plan of care only if it has been approved by a person provided for in the regulations.

Observation showed that a specific assistive device was used as a PASD to assist a resident during specific activities. The DOC indicated that the Physiotherapist (PT) approved the use of the PASD. The PT indicated that they did not approve the PASD for this resident.

Sources: Inspector's observation, resident plan of care, Interviews with Physiotherapist assistant (PTA), PT, and DOC.

2. The licensee has failed to ensure that the use of the PASD has not been approved by a person provided in the regulations.
The PASD under subsection (3) to assist a resident should have been included in the resident's plan of care only if the use of the assistive device has been approved by a person provided under section s. 36 (4) 3.

The resident's plan of care indicated that a specific intervention was to be completed while using the assistive device.

The DOC indicated that the Physiotherapist approved the use of the PASD. The Physiotherapist indicated that they did not approve the PASD for the resident.

Sources: Resident's plan of care. Interviews with PTA, PT and DOC.

WRITTEN NOTIFICATION: Restraints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

The licensee has failed to ensure that a restraint order by the physician was obtained for a resident.

A resident was observed using their assistive devices. The devices were confirmed by the DOC as being restraints.
No orders were found in the resident's medical charts. On a specific day, a Registered Nurse (RN) had stated that a restraint order was required.

Sources: Interview with an RN and DOC, resident's physical and electronic chart.

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcome in a resident's plan of care related to their assistive devices were documented.

Upon the inspector's review of a resident's flow sheet for a specific month, numerous missed entries were noted. The DOC acknowledged that the flow sheets had multiple missed entries and confirmed that the documentation was to be completed every day and every shift by front line staff.

Sources: Resident electronic chart, DOC interview.

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that direct care staff are kept aware of a resident's plan of care .

An RN and Registered Practical Nurse (RPN) had stated that they had not been aware that they were to review and assess a resident's assistive devices and to document as directed in their plan of care. The RN and RPN both confirmed that they had access to the plan of care but had not reviewed it.

A PSW had stated that the resident was only repositioned if care was required and had not been aware of any changes in the plan of care.

Sources: Interviews with an RN, RPN and PSW; resident's plan of care.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure advice of their Residents' Council in carrying out the survey and acting on its annual satisfaction survey results as per a discussion with the Director of Care (DOC).

Sources: Interview with DOC .

WRITTEN NOTIFICATION: Resident / Family Experience Survey

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (a)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (4);

The licensee has failed to ensure that the documented results of their Resident / Family Experience Survey were made available to the Residents' Council as per a

discussion with the Activity director/Resident council assistant.

Sources: Interview with the Activity director/Resident council assistant.

WRITTEN NOTIFICATION: Family Council

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The licensee has failed to ensure that semi-annual meetings were held to establish a Family Council in the home.
The Activity Director had stated in a discussion that the licensee did not hold meetings for the establishment of a Family council.

Sources: Activity Director interview, review of last six family monthly newsletters.

WRITTEN NOTIFICATION: Palliative program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

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

The licensee has failed to ensure that a written Palliative program was in place .

The DOC stated that the licensee did not have a written description of a Palliative program with policies and procedures, and that they will be developing and implementing a Palliative Care Program in 2025.

Sources: Interviews with an RN and DOC.

WRITTEN NOTIFICATION: Dining service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that residents who required assistance with eating and drinking were served a breakfast tray until someone was available to provide the assistance required by the residents.

On a specific day and time, two residents' breakfast trays where observed placed on their bed side table with no staff in sight for assistance. A Personal Support Worker (PSW) indicated the breakfast trays were served at 0800 hours and both residents had not been assisted with their meal as they were working short staff.

Sources: Inspector's observation, PSW interview .

WRITTEN NOTIFICATION: Personal Assistance Service Device

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 120 (1)
Requirements relating to the use of a PASD
s. 120 (1) Every licensee of a long-term care home shall ensure that a PASD used under section 36 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained.

The licensee has failed to ensure that an assistive device used under section 36 of the Act to assist a resident with specific activities, was removed as soon as it was no longer required unless the resident requests that it be retained.

During multiple observations, a resident was observed with their assistive device. The resident's plan of care indicated clear staff instructions as to when the removal of the assistive device was to be completed as not removing the device at specified times, may increase the risk of resident physical injury.

Sources: Inspector's observation. Resident's plan of care. PSW interview.

WRITTEN NOTIFICATION: Continuous quality improvement

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee

s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to ensure that a Continuous quality improvement (CQI) committee was established in the home.
The DOC, who was also the CQI Lead, stated that the home does not have a confirmed CQI committee.

Sources: DOC interview.

WRITTEN NOTIFICATION: Continuous Quality Improvement

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (6) (b)
Continuous quality improvement initiative report
s. 168 (6) The interim report prepared under subsection (5) must,
(b) be provided to the Residents' Council and Family Council, if any; and

The licensee has failed to ensure that the interim report for quality improvement initiatives was provided to the Resident Council.
The DOC, who was also the Continuous quality improvement lead, had stated that no report was provided to Resident's Council.

Sources: Resident council minutes; DOC interview.

WRITTEN NOTIFICATION: Website

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (c)

Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(c) direct contact information, including a telephone number and email address that are monitored regularly for,
(i) the licensee or a senior officer of the licensee or, in the case of a municipal home or a First Nations home approved under Part IX of the Act, a person who is on the committee of management,
(ii) the Administrator,
(iii) the Director of Nursing and Personal Care, and
(iv) all infection prevention and control leads for the home;

The licensee has failed to ensure that direct contact information, including a telephone number and a monitored email address for their Administrator, Director of Care and the Infection prevention and control lead were found on their website.

Sources: Sarsfield Colonial Home website

WRITTEN NOTIFICATION: Website

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (d)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(d) the Ministry's toll-free telephone number for making complaints about homes;

The licensee has failed to ensure that the Ministry's toll-free telephone number for making complaints was found on their website.

Sources: Sarsfield Colonial Home website

WRITTEN NOTIFICATION: Website

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure their current quality improvement initiative was posted on their website.

Sources: Sarsfield Colonial Home website

WRITTEN NOTIFICATION: Website

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (f)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(f) the current version of the emergency plans for the home as provided for in section 268;

The licensee has failed to ensure that their current emergency plan was posted on their website.

Sources: Sarsfield Colonial Home website

WRITTEN NOTIFICATION: Website

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (g)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(g) the current version of the visitor policy made under section 267; and

The licensee has failed to ensure that their current visitor policy was posted on their website.

Sources: Sarsfield Colonial Home website

COMPLIANCE ORDER CO #001 Skin and Wound care

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55
Skin and wound care
s. 55.
(1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.
3. Strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment,

supplies, devices and positioning aids.
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).
(2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

(2.1) The following are authorized persons for the purposes of subsection (2.1):
1. If the skin assessment involves the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, a person who is authorized to perform that act under a health profession Act, the Regulated Health Professions Act, 1991 or any relevant regulation.
2. If the skin assessment does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, either of the following:
i. A member of a health profession acting within their scope of practice.
ii. A nursing student extern who has received training in the performance of skin assessment in accordance with written policies and protocols developed under subsection 53 (3), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to perform skin assessment in a long-term care home and who has been assigned to perform skin assessment by a member of the registered nursing staff of a long-term care home and is under the supervision of that member in accordance with any practices standards and guidelines issued by the College of Nurses of Ontario.
(3) In this section,
"altered skin integrity" means potential or actual disruption of epidermal or dermal tissue. O. Reg. 246/22, s. 55 (3).
"nursing student extern" means a person who is enrolled in an educational program, the successful completion of which meets the educational requirements for the issuance of a certificate of registration as a registered nurse or registered practical nurse as set out in the regulations made under the Nursing Act, 1991.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure their Skin and Wound care program includes at a minimum;

A. Provision of routine skin care to maintain skin integrity and prevent wounds and is

documented for every resident and includes strategies to promote resident comfort and prevention of infection.
B. Strategies documented to transfer, reposition and reduce pressure for residents who are at risk and who have altered skin integrity.
C. Treatments and interventions, including physiotherapy and nutritional care are documented.
D. All residents at risk of altered skin integrity, receive a skin assessment withing 24 hours of their admission to the home, upon return from the hospital and upon return from an absence greater that 24 hours; this is to be documented.
E. All residents who exhitbit altered skin integrity, including skin breakdown, pressure injuries,skin tears or wounds are to:
i) receive a skin assessment using a clinically appropriate assessment tool specifically designed for skin and wound assessments,
ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection,
iii) and are reassessed at least weekly; this is to be documented.
F. Document the use of all equipment, supplies , devices and positionning aids required to relieve pressure, treat pressure injuries , skin tear or wounds.
G. Any resident who is dependent on staff for repositionning, is repositioned every two hours or more as required upon the resident's condition and is documented.
H. Any resident exhibiting a skin condition that requires or may respond to nutrition intervention, is to be assessed by a staff registered dietitican and their recommendations are documented in the resident's plan of care .
I. Provide education to all direct care staff on the Skin and Wound program including the policy and procedures.
The training record shall include
i) the date of the training,
ii) names of the participants and their designation,
iii) who provided the training, and,
iv) an overview of what was covered.
J. Conduct a comprehensive audit of the weekly wound assessment for the two

identified residents for one month.
The audit record shall include
i) the date(s) of the audit,
ii) who completed the audit(s)
iii) the findings and any corrective actions taken.
E) A written record shall be kept of everything required under sections (A)- (J) until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
1.The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was developed and fully implemented, for a resident observed with altered skin integrity, who had not been reassessed at least weekly by an authorized person.

Review of the resident's quarterly skin assessment completed on a specific day, indicated that the resident had altered skin integrity. The progress notes indicated that the resident was identified with the altered skin integrity days later. A treatment was initiated. Months later, the attending physician referred the resident to the wound care nurse as the affected skin area was not healing. The resident's health records and interviews with an RN and the DOC, indicated that the weekly wound assessments were not completed, and no reassessments had been completed; only changes with the same type of treatment were noted during those months.

Sources: Resident's health record, Interviews with an RPN, RN and DOC.

2.The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was developed and fully implemented as all staff who provide direct care to residents had not received

additional skin and wound care training.
An RPN training record did not include training on skin and wound care. The DOC indicated that skin and wound care training has not been completed since 2022.

Sources: RPN training record, and interview with DOC.

3.The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was developed and fully implemented as a resident with altered skin integrity, was not reassessed at least weekly by an authorized person described in subsection (2.1).

Documentation in a resident's progress notes showed that the resident had an area of altered skin integrity on a specific date and a specific treatment was initiated. A couple of months later, this progress notes showed a significant change in the skin area.
Two registered staff members and the DOC acknowledged that the resident's weekly wound assessments had not been completed and that the altered skin integrity to the specific area may have progressed.

Sources: Inspector's observation. Review of a resident's progress notes, assessment records. Interview with an RPN, RN, and DOC.

4.The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was fully implemented as a resident was not repositioned every two hours, which resulted in altered skin integrity.

A resident was observed using an assistive device from 0823 hours to 1215 hours before being assisted by staff. Inspector observation's, during care showed altered skin area on a specific area. The repositioning record for two specific months, indicated the resident was not repositioned consistently as directed.
Interview with a PSW , indicated that the resident was not repositioned while using

their assitive device. An RPN and the DOC indicated that resident was not repositioned regularly which contributed to the Inspector's observation.

Sources: Inspector's observation. Resident's progress notes, Repositioning Record, and plan of care. Interview with staff members.

This order must be complied with by March 14, 2025.

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.