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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 14, 2024

Inspection Number: 2024-1264-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Trillium Court, Kincardine

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10 - 12, 15 - 19 and 22 - 25, 2024.

The following intake(s) were inspected:
Intake: #00113992 - re: Resident fall of with injury.
Intake: #00117768 - re: Neglect of resident
Intake: #00117881 - Complainant re: improper care, housekeeping and IPAC measures.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

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

Rationale and Summary
A Fall Risk Screen at admission showed a resident was at low risk of falling.

Four months later, upon reassessment, they were at moderate risk of falling.

At the time of inspection the resident's care plan stated had not been updated to identify their risk of falls.

The resident was placed at increased risk of harm when the care plan was not

updated upon reassessment that indicated a change in status related to risk for falling.

Sources: Record review of resident care plan, fall risk screen assessments completed December 10, 2023 and April 17, 2024, interview with staff.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that staff and others involved in a resident's plan of care collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, related to falls risk management.

Rationale and Summary
Prior to admission nursing staff identified a resident as at low risk for falls

Upon admission the physiotherapist identified the resident as being at moderate risk for falls.

Three months later the physiotherapy reassessed the resident as at high risk for falls.

The following month the resident fell and sustained a significant injury requiring hospitalization. A nursing assessment completed at that time identified the resident as at moderate risk for falls.

Multidisciplinary falls huddle meeting minutes did not indicate discussion of physiotherapy assessments that were conducted in determining falls risk for the resident, nor did they note participation of the home's physiotherapy department in the meetings.

Failure to ensure collaboration of physiotherapy and nursing teams so that the resident's fall-related assessments were integrated, consistent and complemented each other, may have prevented the team's ability to identify appropriate fall prevention strategies and interventions, placing the resident at increased risk or severity of falls.

Sources:
Review of resident care plan, falls huddle progress notes, interdisciplinary falls huddle binder, physiotherapy assessments from December 17 and March 24, nursing Fall Risk Screen assessments from December 10 and April 17, interview with staff.

WRITTEN NOTIFICATION: Oral Care

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

Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)
Oral care
s. 38 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures;

The licensee failed to ensure that a resident received oral care twice daily to maintain the integrity of the oral tissue.

Rational and summary
A complaint received to the Ministry of Long Term Care said resident had not received oral care and there was mold on the resident's toothbrush.

An observation showed three brushes available for oral care and a partial plate was in a denture cup. All tooth brushes were dry. The care record was signed off as oral care provided.

The home's policy for oral care documented residents receive or are assisted with oral care, including the cleaning of dentures, at least twice daily, AM and HS.

A PSW said they had signed off the resident's oral care provided but they had not completed the care nor had the witnessed the care being done.

The interim ED confirmed oral care was to be provided twice daily or as per resident's plan of care.

Failure to assist the resident with oral care may lead to oral caries, infections or other health issues.

Sources: observations, POC documentation/ Documentation survey report July 2024, LTC Oral Assessment and Care, CARE14-O10.01, reviewed March 31, 2024, interviews with interim ED and staff

WRITTEN NOTIFICATION: Foot care and Nail care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee failed to ensure that nail care was provided to a resident.

Rationale and Summary
A complaint to the MLTC stated the SDM had to clean the resident's nails with a nailbrush.

Observations showed the resident had soiling under their nails.

Staff said nail care was usually provided during their bath. They said that if a resident's nails/hands appeared soiled at other times, they should have been cleaned.

A PSW observed a photo of the resident's nails provided with the complaint, and acknowledged staff should have provided nail care to the resident. They said if a resident refused nail care, it should have been documented.

Sources: complaint, observations, interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 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 comply with their fall prevention and management program related to strategies to reduce or mitigate falls.

In accordance with O. Reg 246/22, s. 11 (1) (b) the home's fall prevention and injury reduction policy states that during a resident's quarterly review, a Fall Risk Assessment is to be completed after the seven-day observation period. Additionally, upon return from hospitalization a resident is to have a Fall Risk Screen completed within 24 hours of readmission to the home.

Specifically, staff did not comply with the Continuous Review and Return from Hospitalization sections of their Fall Prevention and Injury Reduction policy.

A) Rationale and Summary

Under the continuous review section of the home's Fall Prevention and Injury Reduction policy, when a resident is undergoing a RAI quarterly review a Fall Risk Assessment is to be completed following the seven-day observation period.

In March 2024, a resident's RAI quarterly review was completed.

At the time of inspection, a Fall Risk Assessment was not completed following the quarterly review, or anytime thereafter.

By failing to complete a resident's Fall Risk Assessment, further assessment, referrals, falls interventions, or updates to the plan of care were not necessitated, increasing the resident's risk or severity of falling.

B) Rationale and Summary

Under the return from hospitalization section of the home's Fall Prevention and Injury Reduction policy, it states that when a resident returns to the home after being hospitalized a Fall Risk Screen should be completed within 24 hours of readmission.

In April 2024, a resident fell, sustaining a significant injury warranting hospital admission.

Within 24 hours of the resident's readmission to the home, staff did not complete a Fall Risk Screen as per the home's Fall Prevention and Injury Reduction policy.

By failing to complete the Fall Risk Screen for the resident, their fall risk status was not appropriately identified which increased the residents risk of falling as new fall prevention strategies or interventions may have been implemented if it had been completed.

Sources:
Fall Prevention and Injury Reduction policy, resident #005's RAI quarterly assessment completed March 13, progress notes from April 15 and 23, interview with DOC and staff.

WRITTEN NOTIFICATION: Nutritional care and hydration program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee failed to ensure that policies and procedures related to the nutrition and hydration program, specifically relating to nutritional care and dietary services and hydration, had been developed and implemented in consultation with the home's dietitian.

Rationale and Summary
The licensee had policies and procedures in the event of an emergency, which included staffing concerns. There were two emergency menus that could be implemented, but both menus required a cook be available to prepare and cook the

food.

In June 2024, the interim ED developed a contingency plan to be followed as the current emergency menus were not being followed by staff as all of them required a cook. There were many occasions between January and July 2024 when a cook was not available to work.

The Registered Dietitian (RD) stated they had not been involved in the development, implementation or review of the home's policies and procedures nor approval of the emergency menus or the contingency plan for when there was no cook.

Failure to include the RD in the develop and implementation of nutrition and hydration policies and procedures, the contingency plan or menus may result in resident's receiving meals which do not meet the Dietary Reference Intakes (DRI).

Sources: Revera 7 day emergency menu guidelines, Sysco emergency menu, June 6, 2024 Contingency plan - no cook, Trillium Court modified menu, interviews with interim ED and Dietitian

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (b)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both

meals and snacks;

The licensee failed to ensure the home's menu cycle included menus for regular, therapeutic and texture modified diets for both meals and snacks.

Rationale and Summary
In July 2024, the posted menu entrée included either an omelette or a ham sandwich. Observations showed staff requested a puree omelette for three residents and there was none available. Residents were provided ham puree instead.

A Dietary Aid said they often do not have a sufficient amount of textured options or they run out. They were uncertain why there was no omelette puree provided for the meal.

An RPN acknowledged several residents did not receive their preferred entrée as there was no omelette puree available.

The Food Service Manager said the puree omelette option could have been provided if requested.

Sources: observations, posted menus, interviews with Food Service Manager and staff.

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)

Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee failed to ensure that a resident was offered beverages at all snacks.

Rationale and Summary
A resident was wheelchair bound or bed bound and could not self mobilize. They remained in their room.

A complaint to the MLTC said staff were not assisting a resident with fluids and left it outside their door. Seventeen days between May and June 2024, the resident's fluid intake was less than their recommended amount as per their plan of care.

In addition, staff had recorded the resident's snack as refused 82/183 times that they refused snacks and 8/90 times that they were not available for a snack.

An RPN acknowledged staff had not wanted to enter the resident's room to provide beverage/snack assistance.

Sources: Complaint intake, Documentation survey report, plan of care, Nutrition assessment, interviews with DOC and staff.

WRITTEN NOTIFICATION: Food production

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (8)

Food production
s. 78 (8) The licensee shall ensure that, during every hour in which a food service area is operating, there is at least one cook, food service worker or nutrition manager in the food service area who has successfully completed food handler training. O. Reg. 66/23, s. 16.

The licensee failed to ensure that, during every hour in which a food service area is operating, there was at least one cook, food service worker or nutrition manager in the food service area who has successfully completed food handler training.

Rationale and Summary
A complaint was received related to staffing and the quality of the resident meals.

Email communication documented five instances between January and July 2024 when there was no cook working.

The DOC state that nursing staff had to make sandwiches for residents as there was no cook available or no FSM available in January 2024.

The interim ED acknowledged that there had been several times since January to July 2024 when there had not been a cook, Nutrition manager/Food Service Manager or Food service workers working in the home, or anyone with Food Handler training.

Sources: Complaint dated July 3, 2024, Email communication dated July 24, 2024, Interviews with interim ED, DOC and staff

WRITTEN NOTIFICATION: Housekeeping

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (1)
Housekeeping
s. 93 (1) Every licensee of a long-term care home shall ensure that housekeeping services are provided seven days per week.

The licensee failed to ensure that the housekeeping services were provided seven days per week.

Rational and Summary
A complaint was received related to housekeeping and waste management at the home.

The home had one full time housekeeper.

The home's investigation documented that if the housekeeper was on vacation, housekeeping sick time or vacation hours may not be covered.

Email documentation showed that over a two-three week period between May and June 2024, the housekeeping shifts had not been filled on three days.

The interim ED acknowledged the home did not always have a housekeeper working seven days per week.

The risk of not providing housekeeping services 7 days a week is the potential for transmission of potential infectious agents and pest control issues when garbage is not picked up.

Sources: CIS, home's investigation note, June 2024 staff schedule, email dated July 19, 2024 to inspector #659, interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee of the home failed to ensure that there was an IPAC lead who worked a minimum of 17.5 hours a week in the role.

Rationale and Summary
The licensee's IPAC lead relinquished their role around the end of March 2024.

The home had assistance one day a week with IPAC from a registered staff from another nursing home, for approximately one month. The last day for this staff member was July 11, 2024.

Failure to have a dedicated IPAC lead puts the home at risk for lack of oversight for the program, lack of communication between the home and their public health partners and lack of follow up to ensure adherence with IPAC practices.

Sources: interviews with interim ED and DOC

WRITTEN NOTIFICATION: CMOH and MOH

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Rational and Summary
A complaint to the Ministry of Long Term Care stated a resident had been isolated for over 30 days with a gastrointestinal infection. They had no therapy or activities during their isolation.

The Recommendations for Outbreak Prevention and Control in institutions and Congregate Settings, April 2024, stated that symptomatic residents could receive physiotherapy in their room. In addition visits from essential care givers and visitors could take place as long as Additional precautions were followed. Participation in group activities was not recommended.

Email communications between the home and local public health unit (PHU) showed the PHU had advised the home to consider other causes of the resident's GI symptoms; talk internally about resident coming out of room with 1:1, and suggesting the resident be taken outdoors for fresh air or participate in distanced activities.

The Physiotherapy Assistant (PTA) said that there were no exercises provided as the resident was not able to ambulate in the halls and they were too ill. Exercises resumed approximately one week after the home's communication with their local PHU.

The Activity manager stated that resident's involvement in activities decreased during their isolation. They said there was no reason why activation staff could not don PPE to complete 1:1 activities with the resident in their room, and acknowledged one staff member was reluctant to provide 1:1 activities during the resident's isolation period.

Failure to provide the resident with physical activity put the resident at risk of muscle wasting or deterioration in physical health and failure to provide social stimulation put the resident at risk of social isolation or responsive behaviours.

Sources: Complaint, plan of care, progress notes, Lifelab result dated May 22, 2024, Email communications, The Recommendations for Outbreak Prevention and Control in institutions and Congregate Settings, April 2024, interviews with DOC, Activity Manager, PTA and staff.

COMPLIANCE ORDER CO #001 Communication and response system

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (f)
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,
(f) clearly indicates when activated where the signal is coming from; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall develop and implement:
1.Written procedures developed and implemented to direct staff as to their role when there is a malfunction with any part of the resident staff communication response system (RSCRS), or lack of RSCRS equipment. The written procedures should include but not be limited to information on how the staff will be alerted to which resident is calling for staff assistance.
2.Provide education to all staff who use or maintain the RSCRS system on these written procedures. The education is to be documented including dates, name of persons in attendance and what was covered. The documentation is to maintained at the home.
3.If new mobile devices or other devices are implemented, there should be one provided to each care staff and nurse working.
4.Provide education to all staff who use the devices, with regard to how to use the device, directions for charging the device or changing batteries (if so required), and who to notify of any malfunction in the device. The education is to be documented including dates, name of persons in attendance and information reviewed. The documentation is to be maintained in the home.

5.Provide communication provided to residents' and family council about the Home's processes and procedures for when the RSCRS is not functioning with an audible alert; as well as to all substitute decision maker (SDMs) and residents.

Grounds
The licensee failed to ensure the resident staff communication response system notified all staff of where the call was coming from.

Rational and summary
An SDM said that the call bell did not work to alert staff a resident when required assistance with continence management, on more than one occasion.

The marquis was lit but the room numbers displayed did not appear to change in the scroll.

Emails exchanged between staff and the management of the home as well as the management and the corporate office documented there were not sufficient phones for each staff member to be altered to resident calls, the phones did not hold a charge, the marquis and dome lights did not light up and there was no functional panel to identify which resident called.

The home's policy related to the RSCRS said the home would have a process in place to alert the appropriate personnel if the call bell system is not operational. There was not a documented process in place.

Staff said they had expressed concerns that there were not sufficient phones for each staff and there was a problem with the system for more than six months. One said there had been an incident where a staff member was cornered by a resident and did not have a phone to call for assistance.

The interim ED said the system could not be repaired due to its age and they could not purchase additional phones for this system. They acknowledged not all staff would be aware of if a resident was calling for assistance or where the call originated from. They acknowledged there had been no strategies implemented to mitigate the risk to the residents or staff.

Sources: observation, policy Communication and Response, CARE10-O10.11,March 31, 2024, Call Bell System emails dated between June 3 and July 17 2024, between the ED and the homes staff and/or corporate staff, and interviews with interim ED, staff and SDM and residents

This order must be complied with by September 13, 2024

COMPLIANCE ORDER CO #002 Maintenance services

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Ensure the semi-annual nurse call system maintenance is completed, and accurately identifies the nonfunctional components of the resident staff

communication response system (RSCRS), if any.
2.Review and revise, if required, the home's schedule for maintenance checks to the RSCRS.
3.Develop and implement a plan that identifies staff responsible for maintenance of the RSCRS.
4.Ensure equipment is available and in good working condition for staff on every shift. If phones are being used, ensure charging system is functional or batteries are charging.
5.Ensure all maintenance staff revisit and review the environmental services manual for the semi-annual routine RSCRS maintenance. Complete a record of the review, including the date of review and names of staff completing and conducting the review. This record must be kept in the home

Grounds
The licensee failed to ensure that remedial maintenance was being completed on the home's staff-resident communication response system.

Rationale and Summary
In July 2023, semi-annual maintenance to the nurse call system was completed by staff.

In January 2024, semi-annual maintenance to the nurse call system was due but there was no record of completion. In March 2024 the task was modified stating maintenance would be conducted in May 2024.

No further documentation indicated that the semi-annual nurse call system maintenance had been completed.

In July 2024 a maintenance care ticket identified the semi-annual nurse call system

maintenance was completed, with no concerns to the system identified by maintenance staff.

At the time of inspection, hallway signal lights, and audio signal were nonfunctional, and the ceiling marquis was not functioning properly.

The home's Executive Director confirmed that semi-annual maintenance to the system had not been completed as per policy. Additionally, they identified that the maintenance ticket did not indicate concerns with the system, despite staff being aware the system was not functioning properly.

Sources:
Unit observations, maintenance care records, maintenance tasks, interview with the executive director.

This order must be complied with by September 13, 2024

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.