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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 9, 2024

Inspection Number: 2024-1392-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Glen Oaks, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27-30, September 3-6, and 9-11, 2024.

The following intake(s) were inspected:

- Intake: #00113439 - Critical Incident (CI): 2908-000015-24 - Prevention of abuse and neglect.
- Intake: #00114809 - CI: 2908-000019-24 - Falls prevention and management.
- Intake: #00115207 - CI: 2908-000021-24 - Infectious disease outbreak.
- Intake: #00117282 - CI: 2908-000024-24 - Prevention of abuse and neglect
- Intake: #00120002 - CI: 2908-000033-24 - Prevention of abuse and neglect.
- Intake: #00120348 - CI: 2908-000034-24 - Prevention of abuse and neglect.
- Intake: #00120569 - CI: 2908-000035-24 - Prevention of abuse and neglect.

- Intake: #00121621 - Complaint regarding resident neglect, resident assessments, falls prevention and management.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident was free from abuse.

The Ontario Regulation (O. Reg.) 246/22, defines "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary
On a specified date in July 2024, a resident called for help during specified hours; staff did not respond.

A staff responded later, cancelled the call bell, pulled the call bell from the wall, and threw it on the floor. The staff instructed another staff not to place the call bell back. During this time, the resident asked for assistance.

The resident was placed at risk for emotional abuse when they were ignored and shunned, and by the staff's demeanor when the call bell was removed; this violated the resident's right to freedom from abuse.

Sources: Investigation notes, interview with a Director of Care (DOC), resident's care plan.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary
On a specified date in June 2024, a resident experienced a fall which resulted in

injuries. Through the home's investigation, it was determined that a staff provided care alone instead of with a second staff. A DOC confirmed that the staff should have waited for their colleague before providing care to the resident.

Failure to ensure that care was provided to a resident as specified in their plan of care, led to actual harm.

Sources: CI: 2908-000033-24, resident's care plan, the home's investigation notes, and interview with a DOC.

WRITTEN NOTIFICATION: Plan of care

NC #003 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 outcomes of the care set out in the plan of care for a resident were documented.

In accordance with O. Reg. 246/22, s. 11 (1) (b), staff did not comply with the policy titled “Documentation General Guidelines”, that indicated the resident’s clinical record will account for all that transpired with or for the resident from admission to discharge. As well as the home’s policy, titled “Abuse Allegation and Follow-up”, that indicated all physical assessments/examinations were to be recorded with clear descriptions and details. All entries were to be signed, dated with the time of documentation, or indicated that the resident was transported to a medical facility for assessment.

Rationale and Summary

On a specified date in July 2024, a Registered staff spoke with another specified staff to receive a shift end report for a resident.

Later, a different staff entered the resident's room, cancelled the call bell, pulled the call bell from the wall, and threw it on the floor. The staff refused to provide care to the resident after they asked for assistance. Registered staff did not document this event or the overall health status of the resident post incident as they did not receive a report from the specified staff during the remainder of their shift.

The conduct of the Registered staff was in direct violation of the home's documentation and abuse allegation/follow-up policy.

Failure to follow-up with the specified staff at the end of shift did not capture the staff to resident abuse incident immediately; therefore, delayed the investigation process which may have hindered the ability of staff to provide the appropriate assessment or treatment to the resident, placing them at risk of harm.

Sources: CI: 2908-000035-24, LTCH investigation notes, disciplinary action form for staff, interview with a DOC, resident clinical records, the home's policy titled Documentation General Guidelines, and the home's policy titled Abuse Allegation and Follow-up.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that improper or incompetent treatment or care of a resident that resulted in harm to the resident was immediately reported to the Director.

Rationale and Summary
On a specified date in June 2024, there was an incident of improper care. As a result, the resident experienced a change in condition. A Registered staff was aware of the improper care provided on the day it occurred. The Registered staff did not report the incident to the home's management or to the Director of the Ministry of Long-Term Care (MLTC). The home began an investigation and called the after hours reporting line six days after the incident, and subsequently submitted a CI report five days after that.

A DOC acknowledged that the Registered staff should have reported the incident on the day it occurred.

Failure to ensure that an incident of improper care was immediately reported to the Director, put residents at risk of further improper care.
Sources: CI: 2908-000033-24, the home's investigation notes, a resident's care plan, interview with a DOC.

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure the home was equipped with a resident-staff communication and response system that could be easily seen, accessed, and used by a resident.

Rationale and Summary
A resident was at high risk for falls. The care plan identified interventions to reduce their risk for falls including to ensure their call bell was always within reach and for staff to ensure the call bell was attached to the wall and functioning well.

On a specified date in July 2024, a staff removed a resident's call bell from the communication and response system.

At a later time, a different staff entered the resident's room and provided care. The staff did not ensure the call bell was accessible and plugged in during their shift.

It was confirmed by a DOC that the resident did not have their call bell accessible for a specified time-frame.
A Registered staff entered the resident's room in the evening that day and noted the call bell was removed from the wall, unplugged, and located on the floor.

Failure to ensure the call bell was easily seen and accessed placed the resident at risk for the inability to use the call bell to receive assistance and placed them at risk for falls as they were unable to call for assistance when needed.

Sources: Investigation notes, staff interview, CI: 2908-000035-24, a resident's care plan.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (10)
24-hour admission care plan
s. 27 (10) When the care plan is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the care plan. O. Reg. 246/22, s. 27 (10).

The licensee has failed to ensure the care plan was revised because the care set out in the plan was not effective, and the licensee had not ensured that different approaches were considered in the revision of the care plan.

Rationale and Summary
A resident had multiple falls between February 2024 and July 2024.

The post fall assessment and analysis form completed on a specified date in June 2024, indicated the resident's health status declined. Review of the resident's care plan showed no interventional changes were made post-fall and no referral was made to the physiotherapist, which was indicated as per a DOC and a Registered staff.

Failure to update the care plan with different approaches and failure to refer to the physiotherapist placed the resident at risk for continued falls and injury.

Sources: Resident's clinical records, CI: 2908-000019-24, and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(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,

The licensee has failed to ensure that two residents received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A) On a specified date in June 2024, a resident experienced a fall. They were assessed and at the time was identified to have an injury. Three days later, a Physiotherapist was asked to assess the resident and identified another change in condition. A member of the nursing staff was also present during the assessment.

The Physiotherapist confirmed that they documented the change in condition. The resident did not have an assessment completed for this. A DOC acknowledged that

nursing staff should have completed a skin assessment and did not.

Failure to ensure that a resident received a skin assessment had risk for further injury or changes to not be identified.

Sources: Interviews with a Physiotherapist and a DOC; resident's progress notes and skin assessments.

Rationale and Summary
B) On a specified date in May 2024, it was documented that a resident sustained an injury that had occurred on a previous date. On a later date in May 2024, it was documented in the internal investigation interview notes that two staff reported it to the Registered staff. In an interview conducted by the home with the Registered staff it was confirmed the injury was treated but the assessments were not completed. The injury was also not included in the care plan until a later date in May 2024, when the resident complained about the incident.

In an interview with the DOCs it was confirmed the skin and wound assessment was not completed when the injury occurred.

Failure to complete the skin and wound assessment for a resident, increased the risk of further compromising the skin integrity.

Sources: Resident's clinical records, CI report, the home's investigation notes, interview with staff, Policy.

WRITTEN NOTIFICATION: Pain Management

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

Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that a resident's pain was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
On a specified date in May 2024, it was documented that a resident sustained an injury on an earlier date in May 2024. It was later documented in the internal investigation interview notes that two staff reported it to the Registered staff. In an interview conducted by the home with the Registered staff, it was confirmed the injury was treated but the assessments were not completed. The injury was also not included in the care plan until a later date in May 2024.

It was confirmed in an interview with the DOCs that the pain assessment was not completed for the resident on the date the injury occurred in accordance with the Pain Management Policy.

Failure to complete the pain assessment for a resident put the resident at risk for increased pain.

Sources: Resident's clinical records, CI report, the home's investigation notes, interview with staff, Policy.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented.

A) The IPAC Standard for Long-Term Care Homes, indicated under section 5.6 that the licensee shall ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency.

Rationale and Summary
On a specified date in August 2024, when a staff was asked about cleaning high touch surfaces on a specified Neighbourhood, they were unaware of which cleaning solution to use for the task. On the following day, another staff was aware of the correct cleaning solution to use for cleaning high touch surfaces and stated that they were not responsible for cleaning the handrails in the corridor of the Neighbourhood. The IPAC Lead and Assistant Director of Care (ADOC) confirmed that the staff on the Neighbourhood was responsible for cleaning the handrails and confirmed which cleaning solution was to be used.

The home's Cleaning, Disinfection and Sterilization policy identified a High Touch Cleaning Surfaces checklist that staff used to ensure high touch surfaces were cleaned daily. This checklist was reviewed for the time period of the observations

and two dates were not completed.

Failure to ensure that surfaces were cleaned at the required frequency, put residents at risk for spread of potential infections.

Sources: Interviews with staff, IPAC Lead, and ADOC, Cleaning, Disinfection and Sterilization policy.

B) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (d) proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary
During observations on a specified date in August 2024, there was Contact Precautions signage present on a resident's door. Contact Precautions required staff to wear a gown, gloves, and mask when providing direct care. A staff was observed wearing gloves and carrying an item toward the resident's room. They continued to wear the same gloves, donned two masks (double masked) and then a gown.

The IPAC Lead and ADOC confirmed that the staff did not donn their PPE appropriately and should have donned their gloves last. The home's PPE policy indicated under face masks: Do not double mask.

Failure to ensure proper application of PPE posed a risk of spreading infection to other residents.

Sources: Observations, interviews with IPAC Lead and ADOC, Personal Protective Equipment policy.

WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to comply with their written policies for the Medication management system for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policies were (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and must be complied with.

Specifically, staff did not comply with the policies "Medication Orders" and "New Medication Orders" which were included in the licensee's Medication management system.

Rationale and Summary
On a specified date in April 2024, a resident was written a new order by their attending physician. The order was signed as checked by two staff and no other areas on the order form were completed, specifically consent obtained. The home's pharmacy provider's policy, indicated that the staff must sign for the first check after the items listed are completed. The home's Medication Orders policy stated to ensure that all appropriate spaces on the order form have been initialed indicating

all required actions have been completed. This was not done for the order written on that date in April 2024.

A Registered staff stated that it was not regular practice to document if consent was obtained. A DOC confirmed that consent should be documented either in the progress notes or on the order form.

Failure to ensure that the home's Medication management policies were implemented, put a resident at risk for miscommunication whether the order was consented to or not.

Sources: Resident's orders, progress notes, the home's Medication Orders policy, and New Medication Orders policy, interviews with Registered staff and a DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

- Re-educate all specified staff on a specified Neighbourhood regarding the following policies: prevention of abuse and neglect, resident's bill of rights.

- Retain records of the education provided, including: the materials used for the education, how the education was provided, the staff's signatures indicating the education was completed, and the date(s) the education was completed.

Grounds

The licensee has failed to protect residents from neglect by the licensee and physical abuse by anyone.

Section 7 of O. Reg., 246/22, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Section 2 of O. Reg. 246/22, defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A) A resident’s care plan indicated resident was to be provided care twice during the night. Staff were to provide one-person assistance and to ensure care was done.

On a specified date in July 2024, a resident called for assistance for a specified amount of time; staff did not respond.

At a later time, a staff entered the resident’s room to find them with their clothing placed on the floor. A specified staff informed this staff that care was not provided for a while.

The call bell was noted to be non-functioning for approximately two hours on the specified date in July 2024.

Failure to respond to the call bell and provide care to the resident upon their request, and removal of the call bell from the communication response system

prevented them from calling in the event they required the assistance of staff to meet their health, safety, and well-being; this demonstrated neglect.

Sources: Investigation notes, Interview with a DOC, resident's care plan.

Rationale and Summary

B) On a specified date in May 2024, it was documented that a resident sustained an injury that occurred on a specified date in May 2024.

In an interview conducted by the home, it was documented in the internal investigation interview notes that two staff admitted it happened during care of the resident.

It was confirmed in an interview with the DOCs that the incident which caused injury to the resident occurred and was reported by the staff to the Registered staff.

Failure to protect resident from physical abuse by staff, put the resident at risk of injury.

Sources: Resident's clinical records, Critical Incident, Homes investigation notes, interview with staff.

Rationale and Summary

C) On a specified date in July 2024, a resident was interacting with another resident. One resident responded physically to the other resident that resulted in an injury.

It was documented in the clinical records that the resident sustained an injury that required treatment and that the residents were separated and interventions were added to prevent reoccurrence.

In an interview with a DOC, it was confirmed that there was physical injury to a resident as they sustained a wound from the incident.

Failure to protect a resident from physical abuse by another resident led to actual harm.

Sources: Resident's' clinical records, CI: 2908-000034-24, Interview with staff, Home's Internal Investigation Notes.

This order must be complied with by November 15, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

The licensee shall:

- Re-educate all specified staff and all members of management regarding the home's policy on the duty to report, including specific time frames in which events are to be reported to the Director.
- Retain records of the education provided, including: the materials used for the education, how the education was provided, the attendee signature

indicating the education was completed, and the date(s) the education was complete.

Grounds

The licensee failed to ensure that the abuse or neglect of residents that resulted in harm or a risk of harm were reported to the Director immediately.

As per the FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

A) On a specified date in July 2024, a resident was interacting with another resident. One resident responded physically to the other resident that resulted in an injury.

The incident between the residents was documented in the clinical records and the home's internal investigation notes, and it was documented that the Registered staff reported it to Management immediately, however, the Licensee did not report the incident to the Director until a day after the incident.

According to an interview with a DOC, it was confirmed that the incident should have been immediately reported to the Director.

Failure to immediately report the Critical Incident of abuse to the Director, put resident at risk at further harm or abuse.

Sources: Resident's' clinical records, CI: 2908-000034-24, Interview with staff, Home's Internal Investigation Notes.

Rationale and Summary

B) The Afterhours Infoline (AI) was contacted by the home on a specified date in July

2024, and a CI report was submitted by the home three days later related to alleged neglect of a resident by a staff.

A DOC stated a specified staff witnessed the incident and reported it to another specified staff. Both staff did not report the incident to the home's management team.

A DOC stated the specified staff should have reported the incident to the home's management team immediately.

The home's policy titled, "Abuse free communities – prevention, education and analysis", indicated all persons were legally obligated to immediately report the suspicion of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Not reporting the allegation of abuse or neglect to the management team immediately posed a risk for the abuse to continue.

Sources: CI: 2908-000035-24, Review of Afterhours Infoline, LTCH investigation notes, interview with a DOC, resident clinical records, and the home's policy titled, Abuse free communities – prevention, education and analysis.

This order must be complied with by November 15, 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.