Ontario

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

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

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

# Public Report

**Report Issue Date:** December 11, 2025

**Inspection Number:** 2025-1419-0006

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** St. Joseph's at Fleming

**Long Term Care Home and City:** St. Joseph's at Fleming, Peterborough

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 24-27, 2025, and December 1-5, 8, 9, 11, 2025. The inspection occurred offsite on the following date(s): November 28, December 10, 2025.

The following intake(s) were inspected:
- A complaint regarding falls management of a resident.
- A complaint regarding an unexpected resident death.
- Critical Incident (CI) regarding a resident fall with a significant change in condition.
- Follow up #1, CO #001 / 2025-1419-0003, FLTCA, 2021, s. 24 (1), Duty to protect, CDD extended from October 31, 2025, to November 15, 2025.
- Follow up #1, CO #003 / 2025-1419-0003, O. Reg. 246/22, s. 58 (4) (b), Responsive behaviours, CDD extended from October 15, 2025, to November 15, 2025.
- An intake regarding allegations of improper care of a resident.
- A complaint regarding dining supervision of residents.
- An intake regarding allegations of a delay in call bell response time.
- An intake regarding allegations of improper care of a resident resulting in a fall.
- A complaint regarding allegations of improper care of a resident.
- An anonymous complaint regarding resident care and safety.
- An intake regarding allegations of staff to resident physical abuse.
- An intake regarding allegations of neglect regarding a resident not receiving care.
- An intake regarding allegations of improper care of a resident.
- An intake regarding a missing resident >= 3 Hours.
- An intake regarding allegations of staff to resident abuse.
- A complaint regarding concerns with frequents falls, and lack of swallowing assessment.

- An intake regarding a resident fall with a significant change in condition.
- An intake regarding a resident fall with a significant change in condition.
- A complaint regarding allegations of staff to resident physical abuse.
- A complaint regarding allegations of residents being neglected.
- A complaint regarding the vaccination of a resident.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1419-0003 related to FLTCA, 2021, s. 24 (1)
Order #003 from Inspection #2025-1419-0003 related to O. Reg. 246/22, s. 58 (4) (b)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
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) 16.**
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:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

A resident's care needs were not met when they activated their call bell, and staff did not respond a timely manner on several occasions. The resident was emotionally upset following a delay in call bell response time and the response to the complainant indicated a visit from the Social Worker would be arranged. There was a delay in the resident being seen by the Social Worker. The Acting Director of Resident Care (DRC) acknowledged the resident's call bell response times and the visit from the Social Worker should have been timelier to meet the resident's care needs.

**Sources:** A CI, Call Point Detailed Activity Report, internal investigation records and interview with the Acting DRC.

## WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (2)**
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

A resident's blood pressure was elevated. Records indicated it was not rechecked until a few days later.

**Sources:** resident's clinical health record.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1. The allegation of physical abuse by staff towards a resident was not immediately reported to the Director.

**Sources:** A CI, a resident's clinical health records and interviews with staff.

2. The allegation of abuse by a staff towards a resident was not immediately reported to the Director.

**Sources**: A CI, a resident's clinical health records and an interview with staff.

## WRITTEN NOTIFICATION: Powers of Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 66 (3)**
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

A written response was not provided to the Family Council within ten days when the council advised the licensee of a concern.

**Sources:** Family Council Meeting minutes and written response.

## 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;

A complaint was emailed to the Senior Nursing Manager (SNM) indicating a resident's call bell was not accessible. An investigation was completed by SNM which confirmed the staff did not leave the resident's call bell accessible.

**Sources:** A CI, email correspondences, and interview with the SNM.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 40**
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident was found on the floor. The internal investigation concluded that the technique used to position the resident may have contributed to the fall.

The resident was observed with their feet unsupported because the wheelchair footrest was not in place. The resident reported feeling uncomfortable as they had no place to rest their feet.

**Sources:** A CI, Internal Investigation Records, observation and interview with a resident.

## WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The Pain Management Program was not followed to manage a resident's pain. When the registered staff documented in the electronic Medication Administration Record (e-MAR) the resident had pain scores of five and above and a comprehensive pain was not initiated on several occasions. Also, when the resident's pain scores were below five

a short version pain assessment was not completed. The pain management program further indicated to initiate a written plan of care when pain was identified and the care plan should be based on the resident's assessed condition. The Acting DRC confirmed the resident's care plan was not updated with interventions to manage the resident's pain.

**Sources:** The home's Pain Management policy, the resident's clinical records and interview with the Acting DRC.

## WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 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,

1. A resident returned home from hospital on a specific date. The Wound Care Lead confirmed the resident 's surgical incision was not assessed by the registered staff using a clinically appropriate instrument until a later date.

**Sources:** Clinical records and interview with the Wound Care Lead.

2. A resident returned home from hospital, with altered skin integrity. The Wound Care Lead confirmed there was not a documented assessment by the registered staff using a clinically appropriate instrument when they returned home from hospital.

**Sources:** The home's Skin and Wound Care Management policy, the resident's clinical records, and interview with the Wound Care Lead.

## WRITTEN NOTIFICATION: Skin and wound care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

A resident returned home with a surgical incision and wound care orders were written and then clarified the next day. The resident did not receive wound care treatment by the registered staff until the wound care orders were transcribed onto the electronic Treatment Administration Record (e-TAR) a few days later.

**Sources:** The Skin and Wound Care Management policy, the resident's clinical records, and interview with the Wound Care Lead.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

A resident had a device. The staff reported the resident had no output to registered staff and the registered staff performed an assessment and was transferred to hospital. The staff did not follow the plan of care. The registered staff did not complete a comprehensive assessment on the device, prior to the resident being transferred to hospital. The resident returned home from the hospital and the plan of care indicated to document a resident assessment three times a day. Review of the resident’s progress notes indicated on multiple occasions the resident’s assessment was not documented.

**Sources:** The resident’s clinical records, interview with staff.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident had responsive behaviours. Strategies were not developed and implemented to respond to the resident's behaviours,

**Sources:** Resident's clinical health records.

## WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (12) 3.**
Infection prevention and control program
s. 102 (12) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the website of the Ministry of Health.

A resident was not provided vaccination as per immunization schedules posted on the website of the Ministry of Health.

**Sources:** resident's clinical health records, and interview with IPAC Lead.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)**

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

A resident's Substitute Decision Maker (SDM) submitted a complaint that the resident's care needs were not met when they activated their call bell, and staff did not respond a timely manner. The internal investigation record included the response to the complainant. The Acting DRC confirmed there were no further documentation records kept in the home that included, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

**Sources:** Internal Investigation Records and interview with the Acting DRC.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.**
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

A resident had a fall and sustained an injury. The SNM confirmed that the incident resulted in a significant change in the resident's health condition, and should have been reported to the Director.

**Sources:** Clinical records and interview with SNM.

## WRITTEN NOTIFICATION: Administration of drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 140 (2)**
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident did not receive a medication as ordered.

**Sources:** A resident's e-MAR, clinical record, and interview with SNM.

## WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)**
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and

A medication incident involving a resident occurred. The SNM confirmed that a medication incident report was not completed, as required.

**Sources:** A resident's e-MAR, clinical records, and interview with SNM.

## COMPLIANCE ORDER CO #001 Required programs

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

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

1. The Acting DRC or designate is to provide re-education of the home's Fall Prevention Policy. The following re-education shall be completed:
a) Re-educate staff #125 on the Head Injury Routine (HIR) monitoring requirements.
b) Re-educate staff #116 on strategies and expectations for conducting a Head to Toe assessment for resident a post-fall.
c) Re-educate staff #111 on the requirement for registered staff assessment prior to moving a resident.

2. Maintain a documented record of the education content, the names of staff educated, the date of education, and the name of the person who provided the education.

3. The Acting DRC or designated registered staff is to conduct daily audits for a period of two weeks to ensure two residents have their fall prevention interventions in place, as required based on the resident's assessed care needs. The following care needs shall be audited:
a) Audit a resident to ensure their specified intervention in place, as required based on the resident's plan of care.
b) Audit a resident to ensure they have their specified intervention in place during the night and a specific intervention, as required based on the resident's plan of care.

4. Keep a written record of the completed audits, date and time, person completing, and actions taken to correct any deficiencies.

**Grounds**

1. The home's Resident Fall Prevention Program required registered staff to complete an assessment before moving a resident following a fall. A resident experienced a fall and the resident was moved prior to the assessment being completed. The Falls Prevention and Management Program was not followed and there was an increased risk of injury when the resident was moved prior to an assessment by registered staff.

**Sources:** The home's Falls Prevention and Management policy, clinical records, and

interview with the SNM.

2. A resident’s plan of care included the use of a specified intervention as a fall prevention measure. The resident experienced a fall and the intervention was not in place. The SNM confirmed that the fall prevention intervention should have been in place as per the resident’s plan of care. The Falls Prevention and Management Program was not followed and the resident was at an increased risk of falls when the specified intervention was not in place.

**Sources:** The home's Falls Prevention and Management policy, a resident's care plan, clinical records, and interview with SNM.

3. The home’s Resident Fall Prevention Program required completion of a Head Injury Routine for any witnessed fall involving a potential head injury. A resident had a fall and there was incomplete documentation of the head injury assessment. The Falls Prevention and Management Program was not followed when the Head Injury routine had incomplete documentation by registered staff. There was an increased risk of a neurological change when the resident HIR had incomplete entries.

**Sources:** The home's Falls Prevention and Management policy, the home's Head Injury Routine policy, clinical records, and interview with the SNM.

4. The home’s Resident Fall Prevention Program required registered staff to complete an assessment on all unwitnessed falls. A registered staff did not complete a head to toe assessment for a resident after a fall. The Falls Prevention and Management Program was not followed when the head to toe assessment was not completed by the registered staff. The resident was at risk for untreated injury when the assessment was not completed.

**Sources:** The home's Falls Prevention and Management policy, clinical records, and interview with the SNM.

5. A resident was high risk for falls and SNM confirmed a specific fall prevention strategy. The fall prevention intervention was not in place when the resident had a fall. The Falls Prevention and Management Program was not followed when the specific intervention was not in place. The resident was at increased risk of falls when the intervention was not in place.

**Sources:** The home's Falls Prevention and Management policy, clinical records, and interview with the SNM.

6. The home's Resident Fall Prevention Program required to complete a head injury routine for unwitnessed falls. The Falls Prevention and Management Program was not followed when a resident had a Head Injury Routine started at the time of the fall and there were incomplete entries and another entry indicated the resident refused. There was an increased risk of a neurological change when the resident HIR had incomplete entries.

**Sources:** The home's Falls Prevention and Management policy, the home's Head Injury Routine policy, clinical records, interview with the Acting DRC.

7. The Falls Prevention and Management Program was not followed when a resident's plan of care indicated the resident required an intervention for 24 hours a day, and the resident was observed without the intervention in place. The resident was at a increased risk of a fall when the resident's plan of care was not followed.

**Sources:** Observation, the home's Falls Preventions and Management policy, the resident's clinical records and an interview with the Wound Care Lead.

**This order must be complied with by** February 27, 2026

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

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Compliance Order CO #001**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

**Compliance History:**

Prior non-compliance with O. Reg 246/22 s. 53 (1) 1. included:
WN issued on April 15, 2024, in inspection #2024-1419-0001
WN issued on December 9 , 2024, in inspection #2024-1419-0003
WN issued on May 23, 2025, in inspection #2025-1419-0002
CO issued on March 10, 2025, in inspection #2025-1419-0001

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## COMPLIANCE ORDER CO #002 Skin and wound care

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)**
Skin and wound care
s. 55 (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)
(ii) upon any return of the resident from hospital, and

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

1. The Acting DRC or designate will provide education to the registered staff that were working when a resident returned home from the hospital. The education at minimum will include when and where to document a resident's skin assessment upon a resident's return from hospital. Keep a documented record of the content of the education, the names of the registered staff, the date of the education and who provided the education.

2. The Acting DRC or designate will provide education to the registered staff working when a different resident returned home from the hospital. The education at minimum will include when and where to document a resident's skin assessment upon a resident's return from hospital. Keep a documented record of the content of the education, the names of the registered staff, the date of the education and who provided the education.

**Grounds**

1. The Wound Care Lead confirmed there was no documentation indicating a skin assessment was completed by a member of the registered staff upon a resident's return home from hospital. The resident was at risk of altered skin integrity when the registered staff did not complete the resident's skin assessment upon return from the hospital.

**Sources:** Skin and Wound Care Management Program, the resident's clinical records and interview with the Wound Care Lead.

2. The Acting DRC confirmed there was no documented skin assessment upon a resident’s return home from hospital. The resident was at risk of altered skin integrity when the registered staff did not complete the resident's skin assessment upon return from the hospital.

**Sources:** Skin and Wound Care Management Program, the resident's clinical records,

and interview with the Acting DRC and Wound Care Lead.

**This order must be complied with by** February 27, 2026

## 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.