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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: March 4, 2024	
Original Report Issue Date: February 23, 2024	
Inspection Number: 2024-1625-0001 (A1)	
Inspection Type: Proactive Compliance Inspection	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Hillsdale Terraces, Oshawa	
Amended By Patricia Mata (571)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO #001 and #002- amended the compliance due date, the length of time of the audit and who should conduct the audits.
CO #003 – amended the compliance due date.

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Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Hillsdale Terraces, Oshawa	
Lead Inspector Patricia Mata (571)	**Additional Inspector(s)** Jennifer Batten (672)
Amended By Patricia Mata (571)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO #001 and #002- amended the compliance due date, the length of time of the audit and who should conduct the audits.
CO #003 – amended the compliance due date.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-19, 22, 26, 29, 2024

The inspection occurred offsite on the following date(s): January 23, 2024

The following intake(s) were inspected:
- Intake: #00106186 - Proactive Compliance Inspection - PCI

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #001 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 has failed to ensure ten residents had a communication system which was accessible to them at all times.

Summary and Rationale
On several occasions, 10 residents were observed with their call bells out of reach.

During interviews residents stated to get staffs attention they would do some of the following: just call out loudly into the hallway whenever they saw or heard someone passing by; were unsure of how they would secure staff attention if it were required; would access the call bell on their own; or wait for staff to return to their room. Six staff members indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

By not ensuring 10 residents had access to the resident to staff communication system at all times, they were placed at risk of not having their personal needs met and/or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: Observations conducted on January 15 and 26, 2024; review of residents #011, #017, #028, #030, #031, #032, #033, #034, #035 and #036's written plans of care; interviews with residents, PSWs, RPNs and RNs. [672]

WRITTEN NOTIFICATION: PERSONAL ITEMS AND PERSONAL AIDS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items;

The licensee failed to ensure that personal items were labelled, as required.

Rationale and Summary:
Observations conducted from January 15 to 26, 2024, revealed there were multiple personal items in shared resident bathrooms and bedrooms such as used rolls of deodorant, hair combs and brushes, wash basins, bedpans/urinals, finger and toenail clippers, soaps, toothbrushes, toothpastes, and personal make-up which were not labelled as required with the resident's name. Inspector also observed some of these unlabeled shared personal items in tub/shower rooms.

During separate interviews, PSWs, RPNs, RNs and the IPAC Lead verified the expectation in the home was for all personal items to be labelled with the resident's name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident's personal item, which could be unsanitary.

Sources: Observations; interviews with PSWs, RPNs, RNs and the IPAC Lead. [672]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to ensure that the process was implemented to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

Rationale and Summary

Three PSWs were observed attempting to serve and assist residents with food and fluid items but were asking a co-worker about each resident's required diets, textures, likes and dislikes prior to providing the items. Inspector did not observe any nutrition binder or computer available for staff to refer to.

During separate interviews, staff indicated there was supposed to be a computerized tablet attached to the serving cart for staff to refer to during nourishment services, but new carts had been provided "a few weeks ago" and the screens no longer fit on the carts. The Nutrition Services Supervisor (NSS) indicated they had not been informed the computerized tablets could not fit on the new carts and the staff could no longer refer to the tablets on the serving cart. The NSS and Registered Dietitian (RD) verified the expectation in the home was for staff to refer to the dietary lists for each resident prior to serving food and/or fluid items, in order to ensure no changes had been made to a resident's required diet or fluid texture, allergies, likes or dislikes. The NSS indicated the resident diet lists were reviewed and updated daily, as required, and they would not always verbally inform staff of changes made to a resident's dietary needs as these changes were updated within the dietary lists and every residents' plan of care as required.

By not ensuring the process to ensure that food service workers and other staff

assisting residents were aware of the residents' diets, special needs and preferences was implemented, residents were placed at risk of being served food/fluid items which did not meet their nutritional needs or preferences. This could lead to the risk of choking, aspiration or unplanned weight loss due to possible missed meals or nourishment services as a result of being served food/fluid items that did not meet their nutritional needs and/or they did not like.

Sources: Observations; review of residents #002 and #003's current written plans of care; interviews with PSWs #129, #130, the Nutrition Services Supervisor and the Registered Dietitian. [672]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

The licensee failed to ensure that appropriate furnishings to meet the needs of resident #016 were in resident dining areas which included dining room tables at an appropriate height.

Rationale and Summary
Inspector #672 observed a meal service. A resident was observed dining in a lounge. The table being used was significantly higher than the chair, which caused

the resident to need to reach up high and over the table to access their meal.

During separate interviews, the resident and staff acknowledged the table was too high to comfortably meet the resident's needs, but it was the only overbed table available to be used. The resident had to lean forward and reach up high to reach their food and fluid items. The Nutrition Services Supervisor (NSS) indicated they had not been informed there was a concern related to the table being used by the resident during meal services. The NSS stated they should be able to introduce a new table for the resident to use. On one occasion after the interview with the NSS, the resident was observed using a table at an appropriate height and on a separate occasion the table was not at an appropriate height. The RPN indicated they were unaware of the new table which had been implemented that was able to be lowered to meet the resident's needs.

By not ensuring resident #016 had appropriate furnishings which included a dining room table at an appropriate height to meet their needs, they were placed at risk of choking, aspiration or unplanned weight loss due to possible missed meals caused by the resident not ingesting all food and fluid items due to discomfort caused by inappropriate positioning.

Sources: Observations conducted on January 17, 18 and 26, 2024; resident #016's current written plans of care and Kardex; interviews with resident #016, PSW #141, RPN #154 and the Nutrition Services Supervisor. [672]

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an

interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, met at least quarterly to evaluate the effectiveness of the medication management system in the home.

Rationale and Summary:
Inspector #672 observed the internal medication management system within the home. During record review, Inspector noted the interdisciplinary team had met on a quarterly basis to evaluate the effectiveness of the medication management system in the home, but that had not included the Medical Director. The lead for the medication management system in the home indicated the team had met quarterly and had not included the Medical Director. The DOC and Administrator verified they were aware of the expectation for the Medical Director to meet at least quarterly to evaluate the effectiveness of the medication management system in the home.

By not ensuring the interdisciplinary team which included the Medical Director met at least quarterly to evaluate the effectiveness of the medication management system, residents were placed at risk of possible medication incidents due to the lack of an evaluation and analysis.

Sources: Review of the quarterly medication incident analysis and evaluations from 2023; interviews with the lead for the medication management system, DOC and the Administrator. [672]

COMPLIANCE ORDER CO #001 DINING AND SNACK SERVICE

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

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

1) Conduct daily audits of all three meal services for a period of four weeks to ensure safe positioning during meals of residents #002, #003, #006, #007, #008, #009, #010, #013, #014, #015, #16, #017, #018, #020, #021, #022, #023, #024, #031 and #037 is occurring.

2) If unsafe positioning is observed, provide immediate redirection and re-education. Keep a documented record of who received the redirection and what re-education was provided.

3) Keep a documented record of the audits completed and make available for Inspector immediately upon request.

4) Educate all nursing, restorative care, recreation staff, managers and any other staff member or essential caregiver who assists residents with their food and fluid

intake on the required safe positioning of residents during meals and snack services.

5) Provide leadership, monitoring, and supervision from the management in all dining areas during each meal throughout the day, including weekends and holidays for a period of two weeks, to ensure staff adherence with the required safe positioning of residents during meals are occurring. The supervision and monitoring may be delegated to a Registered Nurse or Clinical Lead once the management team is satisfied that staff are consistently demonstrating that residents are placed in the proper position for food and fluid intake.

Grounds
The licensee failed to ensure that proper techniques, including safe positioning, were used to assist 20 residents who each required assistance with eating.

Rationale and Summary
Inspector #672 observed parts of lunch meals and nourishment services on each of the resident home areas (RHAs) and noted 20 residents, who each required either assistance or supervision with eating, were not seated in safe, upright positions during food/fluid intake. PSW and RPN staff indicated that was the usual position for the residents, even during food and fluid intake.

PSW staff were also observed at times to be standing while assisting residents with food/fluid intake, especially during nourishment services outside of the dining rooms.

Review of the residents' health care records and written plans of care did not indicate the residents required to always be tilted while seated in their wheelchair, even during food/fluid intake.

During separate interviews, several PSW, RPN and RN staff indicated the expectation in the home was for all residents to be seated in safe and upright positions during food and fluid intake and repositioned the residents following conversation with the Inspector. Some other staff at times indicated tilted was the usual position for residents to be in, even during food/fluid intake, due to identified reasons such as resident comfort and/or in an attempt to prevent the resident from sliding out of the wheelchair. The NSS and the RD verified the expectation in the home was for all residents to be seated in a safe and upright position and staff members were expected to be seated when assisting residents during food and fluid intake.

By not ensuring residents and staff members were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted; review of residents #002, #003, #006, #007, #008, #009, #010, #013, #014, #015, #16, #017, #018, #020, #021, #022, #023, #024, #031 and #037's current written plans of care and Kardex; interviews with residents, PSWs, RPNs, RNs, dietary aides, the Nutrition Services Supervisor and the Registered Dietitian. [672]

This order must be complied with by April 19, 2024

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 $1100.00, 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:

CO issued during inspection #2022_673672_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.

(A1)

The following non-compliance(s) has been amended: NC #007

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide leadership, monitoring, and supervision from the management team, Clinical Leads or Registered Nurse in all home areas for a period of two weeks by being present on each home area for a period of at least 20 minutes from 0530 to 0830 hours and 1830 to 2200 hours, to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices. Keep a documented record of who was assigned to be out on the resident home areas, including dates and time periods and make immediately available for Inspectors, upon request.

If a Registered Nurse is assigned the task, they should not be scheduled to provide direct nursing care on the home area while they are ensuring adherence with IPAC practices.

2) Conduct daily hand hygiene audits in all resident home areas for a period of two weeks, specifically during nourishment services, to ensure hand hygiene is being completed by both staff and residents, as required. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the

corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

3) Conduct daily audits for one week and then bi-weekly audits for the period of four weeks to ensure PPE is properly stocked in all required PPE stations and is being utilized, donned, and doffed as required. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed. Audits are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

4) Audit all residents in the home who require contact and/or droplet precautions to be implemented to ensure proper signage is posted. Audits are to be conducted once and are to include the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

1) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, the licensee did not ensure support for residents to perform hand hygiene prior to receiving meals and/or snacks according to the additional requirement under the IPAC standard section 10.4(h).

Rationale and Summary

Inspector #672 observed PSW staff delivering lunch trays to residents in their bedrooms but were not observed offering or assisting the residents to perform hand hygiene prior to beginning their meals. During nourishment services, PSW staff were observed providing food and/or fluid items to residents but did not offer/assist any of the residents with hand hygiene prior to them consuming their snack and some staff members did not complete hand hygiene between serving and assisting each resident with their intake.

During separate interviews, several PSWs verified they had not offered or assisted residents with hand hygiene prior to consuming food/fluids and verified the expectation in the home was for staff to do so. The IPAC Lead, Registered Dietitian and Nutrition Services Supervisor indicated the expectation in the home was for staff to offer and/or assist residents with hand hygiene prior to consuming food/fluids items and for staff to complete hand hygiene between each resident they provided assistance with consuming food/fluid items to.

By not ensuring all residents were provided with hand hygiene prior to consuming food and fluids items nor for staff to perform hand hygiene between assisting residents with their intake, the risk for the spread of infectious disease increased.

Sources: Observations conducted; interviews with PSWs, the IPAC Lead, the Nutrition Services Supervisor and Registered Dietitian. (672)

2) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to additional Personal Protective Equipment (PPE) required under section 9.1 (f) of the IPAC Standard.

Rationale and Summary
During observations conducted throughout the inspection, the following infection prevention and control practices related to required additional PPE were observed:

Staff were observed wearing PPE items incorrectly, such as wearing masks under their nose while in the home.

PPE stations outside of resident rooms which required contact and/or droplet precautions were missing one or more of the required PPE items, such as gowns, gloves, masks or disinfectant wipes.

Staff and visitors were observed exiting the home while still wearing their masks. Some Essential Visitors and staff members were observed to be in resident bedrooms where contact/droplet precautions were required to be implemented without wearing all the required PPE items.

Staff members were observed to be sitting on beds in resident bedrooms which required contact/droplet precautions.

During an interview, the IPAC Lead confirmed each staff member had received training regarding how to properly utilize items of PPE. The IPAC Lead indicated the expectation in the home was for every staff member to take responsibility to ensure each PPE station was properly stocked at all times with the required PPE items and all front-line staff had access to PPE supplies.

By not ensuring staff appropriately utilized PPE items and PPE stations were fully stocked at all times, residents were placed at increased risk for the spread of infections within the home.

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

Sources: Observations conducted; interviews with residents, PSWs, RPNs, RNs, the IPAC Lead and the Administrator. (672)

3) The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was complied with.

Specifically, related to required signage under section 9.1 of the IPAC Standard Additional Precautions shall include: e) Point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary
Inspector #672 noted signage posted outside of shared resident bedrooms which indicated one of the residents within the bedroom required contact/droplet precautions to be implemented but did not indicate which resident it was. There was no further signage noted within the bedrooms to indicate which resident required the precautions. Several PSWs were unable to indicate which resident in the bedroom required the precautions.

During separate interviews, the PSW staff indicated they were unsure of which residents within the bedrooms with precaution signage posted required the additional precautions to be implemented. The IPAC Lead verified signage posted outside resident bedrooms did not indicate which resident within the room required the precautions and there was no further signage posted within the bedroom to identify for staff which resident required additional precautions to be implemented

By not ensuring point-of-care signage indicating that enhanced IPAC control measures were in place, residents were placed at increased risk for the spread of infections within the home.

Sources: Observations conducted; interviews with residents, PSWs and the IPAC Lead. [672]

This order must be complied with by April 19, 2024

COMPLIANCE ORDER CO #003 SAFE STORAGE OF DRUGS

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

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

1) Conduct daily audits on each of the resident home areas for a period of two weeks and then biweekly audits for a period of two weeks of resident bedrooms and bathrooms, to ensure that medications and/or medicated treatment creams have not been stored outside of the required area to keep them secured and locked. Audits are to include the rooms which were reviewed, the date the audit was completed, the name of the person who completed the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance. Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds

The licensee failed to ensure that medications were stored in an area which was kept secured and locked.

Summary and Rationale
Inspector #672 observed in multiple resident bedrooms and bathrooms on each of the resident home areas (RHA) unsecured medications and medicated treatment creams left sitting on top of dressers, nightstands and/or counters in shared bathrooms. This was reported to several front-line staff members, along with the medication management program lead in the home. During further observations throughout the rest of the inspection, Inspector continued to observe medications and medicated treatment creams in multiple resident bedrooms and bathrooms throughout the home. On the Ocean View RHA on January 15, 2024, the treatment cart was observed to be sitting in the lounge area, while eight residents were sitting in the immediate area watching television and there were other residents wandering. Inspector was able to push the handle down on the treatment cart and have the drawers open, which stored numerous medicated treatment creams.

Inspector #672 observed a meal service. A resident was provided medication at their table and did not take them for 40 minutes. The RPN did not observe the resident taking the medication. The RPN indicated this was their regular practice for that resident and verified they could not see the medications at all times after they had been delivered to the resident and the expectation in the home was for medications to not be left unsupervised with residents.

During separate interviews, the resident indicated medications were routinely delivered to them in the dining room prior to meal services and they did not take them until the end of the meal. Additionally, four residents and an Essential Caregiver indicated medications and/or medicated treatment creams were

routinely stored in their bedrooms or bathrooms and two residents indicated they self administered the medicated items found in their bedrooms. Six staff members and the medication management program lead and Administrator verified the expectation in the home was for medications and medicated treatment creams to be kept secured and locked at all times in the appropriate area(s) and/or administration cart when not being utilized by staff.

By not ensuring drugs were stored in an area or medication/treatment cart which was kept secured and locked, residents were placed at risk of possible exposure, ingestion and/or inappropriate usage/application of multiple medications and medicated treatment creams.

Sources: Observations conducted from January 15 to 26, 2024; interviews with residents, Essential Caregivers, PSWs, RPNs, RNs, the medication management program lead and Administrator. [672]

This order must be complied with by May 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.