Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
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Original Public Report

Report Issue Date: January 15, 2024	
Inspection Number: 2023-1461-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Glendale Crossing, London	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature**
Additional Inspector(s) Brandy MacEachern (000752) Ina Reynolds (524) Cheryl McFadden (745) Kristen Murray (731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 30, 2023 and December 1, 4-8, 11-14, 18, and 19, 2023.
The inspection occurred offsite on the following date(s): December 15, 2023, and January 8, 2024.

The following intake(s) were inspected:
- Intake #00093718 was a complaint related to plan of care for a resident,
- Intake #00093799 was a complaint related to doors in the home, continence care, and a medication incident,
- Intake #00093923 / Critical Incident System (CIS) #2979-000110-23 was related to a resident fall and alleged neglect,

- Intake #00094650 / CIS #2979-000116-23 was related to alleged neglect for wound care,
- Intake #00094702 was a complaint related to continuing concerns regarding care of a resident,
- Intake #00096271 was a complaint related to improper/incompetent care of a resident,
- Intake #00096611 / CIS #2979-000124-23 was related to alleged neglect of a resident,
- Intake #00097530 was a complaint related to a fall, drug administration, medication incidents, skin and wound care, and plan of care for a resident,
- Intake #00099856 / CIS #2979-000132-23 was related to a resident fall,
- Intake #00101100 / CIS #2979-000140-23 was related to improper/incompetent treatment causing injury to a resident, and
- Intake #00103342 was a complaint related to concerns regarding a medication error.

The following intake was also completed during this inspection:

- Intake #00100709 / CIS #2979-000137-23 was related to a resident fall.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

In October 2023, a resident was found to have a skin wound. Included in the assessment was a treatment plan which identified a type of treatment for the wound. This treatment was mentioned in some sections of the resident's plan of care, but not in others. The treatment was also referred to by a different name than is typically used. Staff were found to be applying the treatment inconsistently and were unsure if the treatment referred to in the plan of care was the actual treatment they had been using.

The Director of Care (DOC) and Inspector #721821 reviewed the resident's care plan, and the DOC confirmed that there was unclear direction since they could not tell if the treatment method described matched what was actually being used. There was also no clear direction on when the treatment should be applied, and the duration it should be applied.

There was risk to the resident that their ongoing skin wound could have delayed healing due to inconsistent application of treatment based on the unclear direction in the resident's plan of care.

Sources: the resident's plan of care, interviews with staff, and direct observations.

[721821]

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
Based on assessment of resident
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.

The licensee has failed to ensure that the continence care set out in a resident's plan of care was based on the needs of that resident.

Rationale and Summary
A resident was identified as having continence issues related to their past medical history. The method for managing these continence issues changed in November 2023, however, the original method remained in the resident's care plan when it was no longer applicable.

An interview with the Director of Care (DOC) confirmed that the resident was not currently using the previous continence management strategy, and that it should not have been in their care plan.

Sources: review of the resident's plan of care, and an interview with the DOC.

[721821]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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 a resident's plan of care, was provided to the resident as specified in the plan.

Rationale and Summary
A Complaint was received by the Director, regarding the care and services of a resident.

The home had received complaints stating that a resident did not have their plan of care followed for a specific intervention on two specific dates. The Director of Quality Assurance and Innovation and the Administrator stated in interviews that the complainant had shown them video footage to confirm these incidents.

The Administrator advised in an interview that there was no harm to the resident, but there was a risk to the resident when this care plan intervention was not followed.

Sources: Staff interviews, complaint response forms, resident care plan.

[000752]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 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,

The licensee has failed to ensure that a resident received immediate treatment and intervention to promote healing and prevent infection to address their skin care needs.

Rationale and Summary
A Critical Incident System (CIS) Report submitted to the Director, indicated that a resident was found with no wound dressing.

In an interview with the Director of Care (DOC), they explained that through their investigation of the incident, they found that a registered nursing staff did not complete a dressing change for the resident after Personal Support Workers (PSWs) had requested the registered nursing staff to change the dressing.

The resident's Treatment Administration Record (TAR) included an as needed task for the wound dressing. There was no documentation showing the task had been performed on the date of this incident. The DOC advised they would have expected the registered nursing staff to attend to the wound dressing immediately when requested by the PSW's.

There was a risk to the resident's health and wellbeing when they did not receive immediate treatment and intervention to promote healing and prevent infection.

Sources: Staff interviews, Clinical records, CIS report.

[000752]

WRITTEN NOTIFICATION: Continence Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable

The licensee has failed to ensure that a resident had sufficient changes to remain clean, dry, and comfortable.

Rationale and Summary
A Critical Incident System (CIS) Report submitted to the Director, indicated that a resident was found by a staff member in a saturated brief. The resident and staff member each confirmed that the resident's brief was found saturated during care on that day.

The resident's care plan indicated specific continence care interventions. In an interview with the Director of Care (DOC), they informed that through their investigation of the incident, it was found that the resident's continence care was delayed. The DOC advised they would have expected the staff to have changed the resident's brief sooner.

There was a risk of damaged skin integrity to the resident when they were not provided with sufficient changes to keep the resident clean and dry.

Sources: Resident interview, staff interviews, care plan, CIS Report.

[000752]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program when a resident's continence management equipment was stored inappropriately in their restroom.

Rationale and Summary
A resident showed Inspector #721821 a concern they had regarding the storage of their continence management equipment. Inspector #721821 noted that the equipment had been placed in the resident's restroom where it would be easily contaminated.

Inspector #721821 interviewed the home's IPAC Lead, who confirmed that the equipment should not have been stored in that manner. They stated that follow up training and education would be done immediately with staff.

There was a risk to the resident for infection when the equipment was not stored properly.

Sources: direct observation, interview with the IPAC Lead.

[721821]

WRITTEN NOTIFICATION: Administration of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Rationale and Summary
A complaint was reported to the Ministry of Long-Term Care regarding the medication management for a resident in the home.

Review of a progress note documented a medication error in July 2023, by a Registered Practical Nurse. The staff documented they had administered a medication to the resident that was ordered for a different resident.

The Director of Care (DOC) in an interview in December 2023, acknowledged the medication error. There was minimal risk to the resident as immediate actions were taken and there were no adverse reactions to the resident.

Sources: Complaint Infoline entries, the resident's clinical records, and interview with the DOC.

[524]

WRITTEN NOTIFICATION: Administration of Drugs

NC #008 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).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A complaint was reported to the Ministry of Long-Term Care regarding the medication management for a resident in the home.

Review of a Medication Incident Report noted an extra dose incident. An order for a medication was entered by the Registered Practical Nurse which had not stated how many millilitres (ml) to administer. The drug count sheet however was filled out by the same nurse, and it was written at the top of the page to administer twice the amount that was prescribed. The Resident had received nine doses in total of the higher dose of medication. Contributing factors were determined to be miscommunication and misunderstanding of the drug order.

The Director of Care (DOC) acknowledged the medication error and stated Pharmacy had mislabeled the amount of the medication that was to be administered and higher doses were given to the resident. There was minimal risk to the resident as there were no adverse effects to the resident.

Sources: Complaint Infoline entries, a Medication Incident Report, the resident's clinical records, and an interview with the DOC.
[524]

WRITTEN NOTIFICATION: Medication Incident Reporting

NC #009 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

The licensee has failed to ensure that a medication incident report was completed when a resident required a medication to be held, and it was not held.

Rationale and Summary
A progress note from September 2023, noted that a resident had been taking a medication and that the medication should have been held for a number of days and it was not held.

The home's Medication Incident Reporting policy stated all medication incidents or near misses (home or pharmacy derived) must be reported and should be documented electronically on MEDeReport or a Care Home defined Medication Incident Report Form.

A Registered Nurse (RN) and the Director of Care (DOC) stated they were aware of this incident and did not complete a medication incident report and one should have been completed.

There was low risk to the resident when the Medication Incident report was not completed.

Sources: The home's policy, Review of Policy 9.2 "Medication Incident Reporting", clinical records for the resident and interviews with an RN and the DOC.

[745]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
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,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision-maker (SDM).

Rationale and Summary
In December 2023, a resident had a near miss medication incident when they attempted to take medications which were not prescribed to them. The near miss medication incident was documented; however, the report was completed for a different resident.

After interviewing the Director of Care (DOC), they stated that the resident's SDM was not notified since the medication incident report was completed for the other

resident. The DOC confirmed that based on the nature of the incident, the resident's SDM should have been notified, and was not.

There was minimal risk to the resident when their SDM was not notified of the medication incident.

Sources: medication incident report, and interviews with the DOC.

[721821]

WRITTEN NOTIFICATION: Medication Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee has failed to ensure that a medication incident involving a resident was documented, reviewed and analyzed.

Rationale and Summary
A progress note documented a medication error in July 2023, by a Registered Practical Nurse. The staff documented they had administered a medication to the resident that was ordered for a different resident. Immediate actions were taken and there were no adverse effects to the resident.

When an incident report was requested from Director of Care (DOC), they stated that they were unable to find one for this incident and acknowledged that a medication incident report should have been completed.

The CareRx pharmacy policy "Medication Incident Reporting" stated in part that the home had a medication incident program in place to ensure there was a consistent method for identification, reporting, reviewing, and analyzing all medication incidents. Staff must report, and document all identified medication incidents on a Medication Incident Report form.

When the home did not complete a medication incident report for the resident there was a missed opportunity for the home to review and analyze causative factors and staff follow up related to the incident.

Sources: CareRx pharmacy "Medication Incident Reporting", review of the resident's clinical records, and an interview with the DOC.

[524]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (1) (a)
Drug destruction and disposal
s. 148 (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs;

The licensee failed to ensure that the written Medication Destruction and Disposal policy as part of the medication management system was implemented for expired medications.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee was required to ensure the medication management system has in place written policies and protocols, and must be complied with. Specifically, staff did not comply with the "Medication Destruction and Disposal" policy, last reviewed June 2023.

Rationale and Summary
On a specific date, it was identified that there were several doses of an expired medication, in the fridge on a home area. A resident was administered one of the expired medications.

The home's Medication Destruction and Disposal policy identified that all medications which became surplus, due to expiry, discontinuation, or change in order, were supposed to have been disposed of and destroyed. The policy also identified that the nurse should have checked medication storage areas, including the refrigerator, on a regular basis (suggested weekly) and identified any medications for disposal.

The Director of Care (DOC) acknowledged that the medication should have been destroyed. A Registered Practical Nurse (RPN) acknowledged that the resident was provided expired medication that were from a previous treatment order and not destroyed as required.

There was risk to the resident related to the medication not being destroyed as required.

Sources: The home's "Medication Destruction and Disposal", a medication incident report, a resident's clinical records including progress notes, and interviews with an RPN, an RN, the DOC, and a MD.

[731]

WRITTEN NOTIFICATION: Recorded Leave of Absence

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 152
Recording of absences
s. 152. Every licensee of a long-term care home shall ensure that each medical

absence, psychiatric absence, casual absence and vacation absence of a resident of the home is recorded.

The licensee has failed to ensure that a casual absence of a resident of the home was recorded.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee was required to ensure the home's Resident Leave of Absence Procedure was complied with. Specifically, staff did not comply with the licensee's procedure number four, which stated residents would be required to sign in and out of the home.

Rationale and Summary

A Complaint was received by the Director regarding the care and services of a resident.

In an interview with the Neighborhood Coordinator, they confirmed that the resident went out on a casual leave of absence for a specific time frame. In review of the Release of Responsibility, Leave of Absence form there was no record of a sign in or sign out on these dates. The home's Resident Leave of Absence Procedure stated that residents were required to sign in and out at the nursing station, so that team members would always be aware of residents' whereabouts. The Administrator clarified in an interview that anyone can document on this sign out form, resident's, their families, or team members.

The Administrator acknowledged that there was no record of sign in or out for the resident on the specific dates, as expected. There was a progress note written at a later date, and a progress note written when the resident returned to the home. The Administrator and Neighborhood Coordinator each confirmed in interviews that a progress note should also have been documented by the afternoon shift when the resident left the home.

There was a risk that staff would not be aware of the resident's location when a resident's casual absence from the home was not recorded.

Sources: Staff interviews, clinical records, Resident Leave of Absence Procedure

[000752]

COMPLIANCE ORDER CO #001 Medication Management System

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
1) Ensure that the registered staff member who administers medications to a resident stays with and observes the resident until all of their medications have been administered;
2) Ensure that an RPN reviews the home's "Administration of Medications" policy;
3) Keep a documented record of the RPN's review of the home's "Administration of Medications" policy, including the their name, signature, and the date the review was completed;
4) Provide education to all registered nursing staff related to checking medication expiration dates; and
5) Keep a documented record of the education, including the date, materials reviewed, who provided the training and the individuals who completed the education.

Grounds
A) The licensee has failed to ensure that a written policy and protocol for the medication management system was implemented for a resident.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the medication management system has in place written policies and protocols, and must be complied with. Specifically, staff did not comply with the "Administration of Medications" policy, last reviewed on February 17, 2023.

Rationale and Summary
In December 2023, a resident had a near miss medication incident when they attempted to self-administer another resident's medications.

Per the home's Administration of Medications policy, registered staff are never to leave medication for the resident to administer to him/herself unless there is a physician's order allowing that person to self-medicate or is listed in their care plan. Per the same policy, registered staff are to remain with the resident until the medication had been swallowed, unless otherwise indicated in the resident's plan of care.

During an interview with the RPN, they confirmed that there was no documentation under a physician's order anywhere that the resident could self-administer their medications. They also said nursing staff were required to monitor a resident when they are administered medications and that they did not remain with the resident until their medications had been swallowed.

Sources: a medication incident report, The home's "Administration of Medications" policy, and an interview with the RPN.

[721821]

B) The licensee failed to ensure that a written policy and protocol for the medication management system was implemented for a resident.

In accordance with O. Reg 246/22 s.11. (1) (b), the licensee was required to ensure the medication management system has in place written policies and protocols, and must be complied with. Specifically, staff did not comply with the "Administration of Medications" policy, last reviewed on February 17, 2023.

Rationale and Summary
A resident was administered one dose of a medication, which had expired.

The home's Administration of Medications policy identified that medications which were expired were supposed to have been discarded. The Director of Care (DOC) stated that medications should be checked for their expiry date prior to administration each time a medication is administered. A Registered Nurse (RN) acknowledged that expired medication was provided to a resident.

There was low risk to the resident related to receiving an expired dose of medication.

Sources: The home's "Administration of Medications" policy, a medication incident report, a resident's clinical records including progress notes, and interviews with an RPN, an RN, the DOC, and a MD.

[731]

This order must be complied with by February 26, 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 to O. Reg. 79/10 s. 114 (3) (a) on June 24, 2021, during inspection 2021_605213_0016.

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.

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.