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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 21, 2023
Inspection Number: 2023-1475-0003
Inspection Type: Complaint Critical Incident System
Licensee: Sharon Farms & Enterprises Limited
Long Term Care Home and City: Earls Court Village, London

Lead Inspector	**Inspector Digital Signature**
Debbie Warpula (577)	Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2023.04.03 08:55:34 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13, 14, 15, 16, 21, 22, 24, 28 and March 1, 2023

The following intake(s) were inspected:

- Intake: #00013473 - Complaint regarding medication administration and falls;
- Intake: #00013824 - Fall of a resident resulting in injury;
- Intake: #00015123 - Allegation of resident neglect; and
- Intake: #00018445 - Complaint regarding resident neglect.
- The following intake was completed in the CIS inspection: Intake #00014137 - Fall of a resident resulting in injury.

Inspector Brandy MacEachern (000752) was also present during this inspection.

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

Infection Prevention and Control

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Attending Physicians

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 88 (4)

The licensee has failed to ensure that an Attending Physician and two “Resident 2” Physicians, had a written agreement with the home.

Rationale and Summary:
A review of the home’s policy "Attending Physician Agreement" revised May 4, 2020, indicated that Attending Physicians would sign individual agreements with the home annually. A signed agreement was retained on file for each Attending Physician and reviewed and re-signed annually. If the Attending Physician was unavailable at any time, for any reason, the Attending Physician would provide a replacement and inform the Administrator and Medical Director. The policy had not contained any reference to “Resident” Physicians.

During a review of a resident’s physician orders, Inspector #577 found orders and physician progress notes documented by two “Resident 2” Physician’s, for an Attending Physician. Inspector noted a physician order written by one “Resident 2” Physician, where they discontinued a specific medication for the resident, and the order was not co-signed by the Attending Physician.

During a record review of Attending Physician Agreements and the Medical Director agreement, Inspector #577 found that the Attending Physician and the two “Resident 2” Physicians did not have a written Physician Agreement. The inspector reviewed two written agreements for two other Attending Physicians, from a previous year.

During an interview with the Attending Physician, they advised that they started working for the home four years prior, and had not recalled signing a written agreement with the home. They reported that “Resident” Physicians work under them supervised or unsupervised, with the Attending Physician being available by phone, and there were no written agreements with “Resident” Physicians.

During an interview with the Administrator, they advised that the Attending Physician did not have a written agreement with the home. They reported that the other written agreements from a previous year, were considered still enforced.

Sources: review of the home’s policy "Attending Physician Agreement”, two written Attending Physician Agreements, Attending Physician Agreement for the Attending Physician dated February 2023, a physician order written by a “Resident 2” Physician, interviews with the Attending Physician and the Administrator.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (c)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

Rationale and Summary:
During a review of the home’s policy "Zero Tolerance of Abuse and Neglect" revised January 3, 2023, Inspector #577 found missing components that were required to be in their policy.

In an interview with the Director of Care (DOC), together with Inspector #577 reviewed the policy and they confirmed that measures and strategies to prevent abuse and neglect were not documented in their policy.

Sources: review of the home's policy "Zero Tolerance of Abuse and Neglect", and an interview with the DOC.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (e) (i)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents identified training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

Rationale and Summary:
During a review of the home's policy "Zero Tolerance of Abuse and Neglect" revised January 3, 2023, Inspector #577 found missing components that were required to be in their policy.

In an interview with the DOC, together with Inspector #577 reviewed the policy and they confirmed that the identified training was not documented in their policy.

Sources: review of the home's policy "Zero Tolerance of Abuse and Neglect", and an interview with the DOC.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (e) (ii)

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents identified training and retraining on situations that may lead to abuse and neglect

and how to avoid such situations.

Rationale and Summary:
During a review of the home's policy "Zero Tolerance of Abuse and Neglect" revised January 3, 2023, Inspector #577 found missing components that were required to be in their policy.

In an interview with the DOC, together with Inspector #577 reviewed the policy and they confirmed that the identified training was not documented in their policy.

Sources: review of the home's policy "Zero Tolerance of Abuse and Neglect", and an interview with the DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

The licensee has failed to ensure that a complaint that could not be investigated and resolved within 10 business days, a follow-up response was provided with an explanation of what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Rationale and Summary:
A review of the home's policy "Management and Reporting of Complaints" revised January 3, 2023, indicated it was expected that staff would follow all the steps for initiating and managing complaints which included investigating, resolving where possible, reporting, tracking, trending, and the actions taken to prevent a reoccurrence. Additionally, a follow up response would be provided as soon as possible which indicated what the home had done to resolve the complaint or that the home believed the complaint to be unfounded and the reasons for that finding.

A resident's family member submitted a written complaint which alleged neglect of the resident. The Administrator sent an initial response letter to the resident's family member

which acknowledged the written complaint. A second response letter was sent seven days later, which indicated that the home was waiting for a written review from a health care practitioner. A third written response was provided to the resident's family member which did not include the required details.

The DOC acknowledged they did not send a follow up response to the resident's family member with an explanation of what had been done to resolve the complaint or whether they believed the complaint to be unfounded. The DOC advised that they had tried contacting the complainant.

Sources: Review of the complaint letter from the resident's family member, the home's written responses to the complainant, the home's Complaints Log, the home's policy "Management and Reporting of Complaints", and interviews with the DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to the resident's family member, who made a complaint concerning the care of the resident, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:
A resident's family member submitted a written complaint email regarding the resident's care which was received by the home. On three separate dates, the Administrator sent a response letter to the resident's family member. The response letter did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Sources: Review of the complaint letter from a resident's family member, response letters from the Administrator.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaints related to a resident, including the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary:
The home received a written complaint concerning alleged neglect.

The home's policy "Management and Reporting of Complaints" revised January 3, 2023, indicated that all complaints/concerns would be documented on the complaint/concern tracking log by the person receiving the complaint/concern. In the event, an email was received which outlined a concern, the CSR form was to be completed and added to the tracking log.

Inspector #577 reviewed the home's "Complaints Management Tracking" for 2022, concerning verbal and written complaints. The log did not show the concerns as documented.

The DOC stated the concerns and actions were not documented as required on the complaints log.

The home's failure to keep a documented record of the complaints received pose a risk of the issues related to residents not being dealt with and resolved promptly.

Sources: review of the complaint letter from a resident's family member, a CIS report, review of the home's complaints log, the home's policy "Management and Reporting of Complaints", and

interview with the DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee has failed to ensure that a documented record was kept in the home that included a final resolution.

Rationale and Summary:
The home received a written complaint concerning alleged neglect.

The home's policy "Management and Reporting of Complaints" revised January 3, 2023, indicated that all complaints/concerns would be documented on the complaint/concern tracking log by the person receiving the complaint/concern. In the event, an email was received which outlined a concern, the CSR form was to be completed and added to the tracking log.

Inspector #577 reviewed the home's "Complaints Management Tracking" for 2022, concerning verbal and written complaints. The log did not show the concerns as documented or a final resolution.

The DOC stated the concerns were not documented as required on the complaints log and there was no documented record of a final resolution.

The home's failure to keep a documented record of the complaints received pose a risk of the issues related to residents not being dealt with and resolved promptly.

Sources: review of the complaint letter from a resident's family member, CIS report, review of the home's complaints log, the home's policy "Management and Reporting of Complaints", and an interview with the DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary:
The home received a written complaint concerning alleged neglect.

The home's policy "Management and Reporting of Complaints" revised January 3, 2023, indicated that all complaints/concerns would be documented on the complaint/concern tracking log by the person receiving the complaint/concern. In the event, an email was received which outlined a concern, the CSR form was to be completed and added to the tracking log.

Inspector #577 reviewed the home's "Complaints Management Tracking" for 2022, concerning verbal and written complaints. The log did not show the concerns as documented.

The DOC stated the concerns were not documented as required on the complaints log and there was no documented record of any responses provided to the resident's family member.

The home's failure to keep a documented record of the complaints received pose a risk of the issues related to residents not being dealt with and resolved promptly.

Sources: review of the complaint letter from a resident's family member, CIS report, review of the home's complaints log, the home's policy "Management and Reporting of Complaints", and an interview with the DOC.

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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with IPAC Standard for Long-Term Care Homes and with home's Hand Hygiene (HH) policy related to staff not providing resident prior to a meal service.

The IPAC Standard for Long-Term Care Homes, indicated under section 10.1 that the licensee should ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

O. Reg. 246/22, s. 102 (2)(b) requires the licensee to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary:
During observations of a meal service on a specified home unit, Inspector #577 observed a Personal Support Worker (PSW) offer residents aloe wipes for hand hygiene prior to their meal. The inspector observed that there was no availability of Alcohol-Based Hand Rub (ABHR) in the dining room. Inspector noted that the aloe hand wipes did not contain alcohol.

During an interview with two PSW's, they indicated that they had always used aloe wipes for resident hand hygiene before meals.

A review of the home's policy "Hand Hygiene Program for Persons Served", revised November 30, 2022, indicated that for resident hand hygiene, moistened towelettes followed by ABHR should be used. Towelettes containing alcohol could be used as a substitute for ABHR. For independent and persons unable to perform their own hand hygiene, assistance would be provided by the PSW before meals and snacks.

An email communication from the Middlesex-London Public Health Nurse (PHN), advised Inspector #577 that best practice was staff offering and having ABHR (70-90 percent) available to residents. Additionally, if residents refused ABHR, they should consider asking the residents to wash their hands with soap and water at a sink.

During an interview with the DOC, they indicated that the previous Middlesex-London PHN had advised them that it was acceptable practice to have used aloe wipes if residents declined ABHR. The DOC confirmed that staff were to offer ABHR and if a resident declined, then they were to offer aloe hand wipes. Advised that they checked each floor on that day and found that the staff on two specified home units had not offered ABHR to the residents prior to the meal service.

Staff not implementing the home's IPAC program by not providing proper hand hygiene with ABHR to residents prior to their meal service, put residents at risk of potentially spreading healthcare associated infections.

Sources: IPAC observations in the home, review of home's policy "Hand Hygiene Program for Persons Served", the IPAC Standard for Long Term Care Homes (April 2022); interviews with two PSWs, Middlesex-London Public Health Nurse and the DOC.

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COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

A) Director of Care (DOC) or designate will conduct documented weekly audits of residents with

a specific condition that have specific interventions to ensure those residents are being monitored as per their orders. Audits will continue until the Compliance Order is complied by an inspector;

B) Ensure a specified resident receives care as per their order;

C) Educate all registered nursing staff on the home's specific policy; keep a record of the training and dates completed;

D) Provide training for an Attending Physician, two "Resident 2" Physicians, regarding accountabilities in ensuring that residents with a specific condition are monitored as applicable. Keep a record of the training and dates completed; and

E) Document the role and responsibilities of "Resident" Physicians in the provision of care of residents.

Grounds
The licensee has failed to ensure that two residents were protected from neglect when they had not received specific monitoring for a specific medical condition.

Section 7 of the Ontario Regulation 246/22 and section 5 of the Ontario Regulation 79/10 defines neglect as: the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well -being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

A review of the home's policy "Zero Tolerance of Abuse and Neglect" revised January 3, 2023, indicated that the home acknowledged that every person served had the right to freedom from abuse and neglect; it defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of one of the home's policies showed there were specific expectations for care within the home.

A review of Care Rx policy "New Admission - Re-Admission Orders" revised August 2021,

indicated that staff were responsible for scanning physician orders to the pharmacy.

Non-compliance with: FLTCHA, 2021 s. 24 (1)
A) A CIS report was received by the Director which included allegations of neglect.

A complaint was received by the Director which alleged neglect of a resident. The report entailed concerns that the resident's specific medical condition was not monitored and they had frequent falls.

A record review of the resident's admission orders indicated specific monitoring. A review of physician orders written by a "Resident 2" physician, on an identified date, indicated that a specific medication was discontinued. The order was not co-signed by an Attending physician.

A review of the resident's care plan did not contain any interventions related to monitoring of their specific medical condition.

A review of the resident's clinical record indicated that their specific medical condition was not monitored, which had a negative impact on the resident's health.

During an interview with the DOC, they advised that an RPN and an RN failed to process the resident's admission orders; staff should have followed the order for specific monitoring; a specified test was ordered to be completed at a set schedule and the resident was not monitored in accordance with the home's expectation and a specific medication was discontinued.

Staff not processing the resident's admission order set, not monitoring the resident's medical condition, and the discontinuation of their specific medication put the resident at actual risk and they suffered a specific medical condition.

Sources: CIS report, a complaint, review of the resident's admission order set, care plan, progress notes, specific report, physician orders, email thread from the Medical Director and DOC, Care Rx policy "New Admission -Re-Admission Orders", home's policy "Zero Tolerance of

Abuse and Neglect", interviews with an Attending Physician, and the DOC.

Non-compliance with: FLTCA, 2021, s. 24 (1) and with LTCHA 2007, s. 19 (1)
B) On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred after April 11, 2022, where the requirement was under s. 24 (1) of the FLTCA. Non-compliance with the applicable requirement also occurred prior April 11, 2022, which falls under s. 19 (1) of the LTCHA, 2007.

Section 7 of the Ontario Regulation 246/22 and section 5 of the Ontario Regulation 79/10 defines neglect as: the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well -being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

A complaint was received by the Director which included an allegation of neglect.

A record review of the resident's admission orders indicated orders for specific monitoring for specified times.

A review of the resident's care plan did not contain any interventions related to specific monitoring.

During an interview with an RPN, they advised that registered staff were responsible to scan admission order sets to pharmacy.

During an interview with the DOC, they indicated that they were not aware of specific monitoring not being completed over a specific time period. Together, DOC and the inspector reviewed the resident's admission order set which indicated specific monitoring, and they advised that the orders were not scanned to pharmacy, as there was not an eMAR that indicated specific monitoring. They advised that staff were responsible to have been monitoring residents and should have followed up with pharmacy.

Staff not following the resident's admission order set and not following the specific monitoring

over a specific time period put the resident at actual risk.

Sources: a complaint, review of the resident's admission order set, care plan, progress notes, specified report, physician orders, home's policy "Zero Tolerance of Abuse and Neglect", Care Rx policy "New Admission -Re-Admission Orders", email thread from the Medical Director and DOC, interviews with an RPN and the DOC.

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This order must be complied with by May 2, 2023

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:

A CO was issued during inspection #2021_777731_0014 under LTCHA, 2007 s. 19 (1)

This is the first time the licensee has failed 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 Medication Management System

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

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

A) Educate all registered nursing staff on Care Rx medication policies related to processing orders;

B) Maintain a record of completed education; and

C) DOC or designate will conduct documented weekly audits of physician orders to ensure registered staff are processing orders and performing double checks. Audits will continue until the Compliance Order is complied by an inspector.

Grounds

The licensee has failed to comply with Care Rx medication policies related to admission orders included in the required Medication Management Program for two residents.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, staff did not comply with Care Rx policies “New Admission -Re-Admission Orders” and “Prescriber’s Orders”.

Rationale and Summary:
A review of Care Rx policy “New Admission - Re-Admission Orders” revised August 2021, indicated that staff were responsible for scanning physician orders to the pharmacy.

A review of Care Rx policy "Prescriber's Orders" revised August 2021, indicated that the nurse doing the first check on the orders must ensure that the order had been received by pharmacy by reviewing the electronic order with the paper order. The nurse doing the second check on the orders must ensure that the order was reflected into the electronic medication administration record/treatment administration record (eMAR/TAR), compare the order against the eMAR/TAR.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
A) A CIS report was received by the Director which included an allegation of neglect.

A complaint was received by the Director which alleged neglect of the resident, as the resident had not received specific monitoring for their medical condition.

A review of the resident's admission orders indicated specific monitoring at specified times and a specific test every four months.

A review of the resident's clinical record indicated that their medical condition was not monitored.

During an interview with the DOC, they advised that an RPN and an RN failed to process the resident's admission orders.

Staff not processing the resident's admission order set and not providing specific monitoring put the resident at actual risk.

Sources: CIS report, a complaint, review of a resident's admission order set, physician orders, Care Rx policy "New Admission -Re-Admission Orders", "Prescriber's Orders", and an interview with the DOC.

Non-compliance with: O. Reg 79/10, s. 114
B) On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg.

79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred after April 11, 2022, where the requirement was under s. 123 (3) (a) of the FLTCA. Non-compliance with the applicable requirement also occurred prior April 11, 2022, which falls under s. 114 of the LTCHA, 2007.

A complaint was received by the Director related to an allegation of neglect.

A record review of the resident's admission orders indicated orders for specific monitoring at specified times.

During an interview with an RPN, they advised that registered staff were responsible to scan admission order sets to pharmacy.

During an interview with the DOC, they advised that the admission orders were not scanned to pharmacy and staff should have followed up with pharmacy.

Staff not processing the resident's admission order set and not providing specific monitoring for nine months put the resident at actual risk.

Sources: a complaint, review of a resident's admission order set, physician orders, Care Rx policy "New Admission -Re-Admission Orders", "Prescriber's Orders", and an interview with an RPN and the DOC.

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This order must be complied with by May 2, 2023

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.