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
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 13, 2024

Inspection Number: 2024-1200-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Lindsay Nursing Home, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9-11, 15-18, 21-25, 2024

The following intake(s) were inspected:

Intakes related to an allegation of missing money of a resident.
An intake related to an allegation of improper/incompetent care of a resident.
An intake related to an allegation of staff to resident neglect.
An intake related to a resident fall.
An intake related to an allegation of resident to resident physical abuse.
An intake related to an allegation of staff to resident verbal abuse.
An intake related to an unexpected death of a resident
An intake complaint related to medication administration and resident care services.

The following intake was completed during this inspection:
An intake related to a resident fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #013 from Inspection #2023-1200-0003 related to O. Reg. 246/22, s. 140 (2)
Order #001 from Inspection #2024-1200-0001 related to FLTCA, 2021, s. 6 (10) (b)
Order #002 from Inspection #2024-1200-0001 related to O. Reg. 246/22, s. 41 (1) (a)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

1) The licensee failed to ensure the provision of care set out in the plan of care for a resident was documented related to personal hygiene.

Rationale and Summary

A complaint was submitted to the Director alleging improper care of a resident.

The Documentation Survey Report generated from Point of Care (POC) was reviewed. Documentation to support that personal hygiene was completed could not be found on one shift. Documentation in the progress notes to support why these interventions were not signed as completed was not found.

A Personal Support Worker (PSW) indicated that documentation should be completed in POC on a tablet at the time of care.

By failing to ensure documentation was completed, there was a risk that staff could potentially miss providing the required care or monitoring.

Sources: A resident's clinical health records and an interview.

2) The licensee failed to ensure the provision of care set out in the plan of care for a resident was documented related to continence management.

Rationale and Summary

A complaint was submitted to the Director alleging improper care of a resident.

The Documentation Survey Report did not include documentation to support that continence management interventions occurred on one shift for several hours. Documentation in the progress notes to support why these interventions were not signed could not be found.

A PSW indicated that documentation should be completed in POC on a tablet at the time of care.

By failing to ensure documentation was completed, there was a risk that staff could potentially miss providing the required care or monitoring.

Sources: A resident's clinical health records and an interview.

3) The licensee failed to ensure the provision of care set out in the plan of care for a resident was documented related to a safety intervention.

Rationale and Summary

A complaint was submitted to the Director alleging improper care of a resident.

The Documentation Survey Report documentation was reviewed. Documentation for monitoring safety interventions could not be found to support they were in place or functioning on a few shifts. Documentation to support why these interventions were not signed for was not found in the progress notes.

A PSW indicated that documentation should be completed in POC on a tablet at the time of care.

By failing to ensure documentation was completed, there was a risk that staff could potentially miss providing the required care or monitoring.

Sources: A resident's clinical health records and an interview.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure a resident was free from neglect.

For the purposes of the Act and this Regulation,
"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety, being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding alleged staff to resident neglect of a resident.

Registered Practical Nurse (RPN) #110 was notified that a resident required treatment to their altered skin integrity. There was no indication of previous documentation of a wound. The RPN notified the on-call manager of their concerns and an investigation commenced. The Director of Care (DOC) confirmed an investigation was completed. The outcome of the investigation found that RPN #111 failed to follow the licensee's skin and wound management program for the resident when they became aware of the altered skin integrity a week prior to the reported incident.

The following non-compliance was identified within this report specific to the

resident's skin and wound care:

-Written Notification- O. Reg 246/ 22, s. 55 (1) 1. The licensee failed to ensure the resident was provided the provision of routine skin care to maintain skin integrity and prevent wounds.
- Written Notification - O. Reg 246/ 22, s. 55 (2) (b) (ii) The licensee failed to ensure the resident received immediate treatment and interventions to promote healing and prevent infection when exhibiting altered skin integrity.
- Written Notification - O. Reg 246/ 22, s. 55 (2) (b) (i) The licensee failed to ensure the resident received a skin assessment when exhibiting altered skin integrity.
- Written Notification - O. Reg 246/ 22, s. 55 (2) (a) (ii) The licensee failed to ensure the resident received a skin assessment upon a return from the hospital.

A series of failures and omissions lead to the neglect of the resident.

The Medical Doctor completed an assessment several days after the reported incident which described the severity of the wound.

By failing to provide the resident with the appropriate treatments, at the appropriate time, lead to neglect of the resident.

Sources: A CIR, a resident's clinical records, and an interview.

WRITTEN NOTIFICATION: Promote zero tolerance of abuse and neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in

section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rational and Summary

A CIR was submitted to the Director for an alleged staff-to-resident verbal abuse that happened between a PSW and a resident the day prior.

The licensee investigated the incident and found that PSW #122 verbally abused a resident. PSW #123 provided testimony during the home's investigation that they overheard the verbal abuse, and they did not immediately report the allegation of abuse to a nurse or manager.

The DOC confirmed that the PSW did not report the alleged verbal abuse.

The licensee's Zero Tolerance of Abuse and Neglect Policy states that staff must follow two types of procedures (internal and external) for reporting all alleged, suspected, or witnessed incidents of abuse and neglect. The PSW did not follow the licensee's policy of Zero Tolerance for Abuse and Neglect.

Failing to comply with the home's zero-tolerance of abuse and neglect policy for a resident resulted in late reporting to the Director and a delayed internal investigation.

Sources: A CIR, the licensee's investigation documentation, and an interview.

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 (1) 1.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
1. The provision of routine skin care to maintain skin integrity and prevent wounds.

The licensee failed to ensure a resident was provided the provision of routine skin care to maintain skin integrity and prevent wounds.

Rationale and Summary

A CIR was submitted to the Director regarding alleged staff to resident neglect.

RPN #110 was notified by a PSW that the resident's altered skin integrity required a new dressing. RPN #110 was unable to identify previous documentation of the wound.

The home completed an investigation which included speaking to the care staff. The DOC indicated that RPN #111 confirmed they became aware of the altered skin integrity approximately a week prior to RPN #110 discovering the wound. RPN #111 indicated they had applied the only dressing they could find. The DOC indicated it was an inappropriate dressing. All PSWs denied seeing or being aware of the resident's altered skin prior to RPN #110's discovery.

The licensee's policy and procedure for Prevention of Skin Breakdown Procedures indicated that all resident's skin should be inspected by staff providing direct care

for any altered skin integrity daily, and with every bath or shower.

The DOC indicated the PSWs were to complete shift to shift skin monitoring and record their observations in the electronic documentation form. PSWs were to inform the Registered Nurse (RN) verbally of any new issues.

By failing to ensure the resident's skin was inspected by staff providing direct care for any altered skin integrity daily, and with every bath or shower put the resident at risk for lack of immediate treatment.

Sources: A CIR, a resident's clinical records, Prevention of Skin Breakdown Procedures, and an interview.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure a resident received a skin assessment upon a return from the hospital.

Rationale and Summary

A CIR was submitted to the Director regarding alleged staff to resident neglect.

The resident was sent to the hospital for further assessment and treatment as a result of the reported incident. Upon return from the hospital transfer, there was no indication of a skin assessment.

The DOC indicated that the expectation was that a head-to-toe assessment was to be done upon a return from the hospital.

By failing to ensure the resident received a skin assessment upon return from the hospital put the resident at risk of delayed treatment.

Sources: A CIR, a resident's clinical records and an interview.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure when a resident was exhibiting altered skin integrity, they received a skin assessment.

Rationale and Summary

A CIR was submitted to the Director regarding alleged staff to resident neglect.

RPN #110 was notified by a PSW that the resident's altered skin integrity required a new dressing. RPN #110 was unable to identify previous documentation of the wound.

The home completed an investigation which included speaking to the care staff. The DOC indicated that RPN #111 confirmed they became aware of the altered skin integrity approximately a week prior to RPN #110 discovering the wound. RPN #111 indicated they had applied the only dressing they could find. The DOC indicated it was an inappropriate dressing. All PSWs denied seeing or being aware of the resident's altered skin prior to RPN #110 discovery. The DOC indicated the long-term care home had supplies available for the appropriate treatment.

The licensee's policy for New Wound Procedure directs the staff to take a picture of the wound or skin impairment and complete assessments which included the wound bed, exudate, per-wound, and pain as applicable to the wound. The DOC indicated that the application to take a picture of a wound, prompts the nurses to complete an assessment and will trigger a date for the next assessment.

The long-term care home's investigation confirmed there was no clinically appropriate assessment completed when the altered skin integrity was identified.

By failing to ensure the resident received a skin assessment put the resident at risk of inappropriate and delayed treatment.

Sources: A CIR, a resident's clinical records, and an interview.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (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 failed to ensure when a resident was exhibiting altered skin integrity that they received immediate treatment and interventions to promote healing and prevent infection.

Rationale and Summary

A CIR was submitted to the Director regarding alleged staff to resident neglect.

RPN #110 was notified by a PSW that the resident's altered skin integrity required a new dressing. RPN #110 was unable to identify previous documentation of the wound.

The home completed an investigation which included speaking to the care staff. The DOC indicated that RPN #111 confirmed they became aware of the altered skin integrity approximately a week prior to RPN #110 discovering the wound. RPN #111 indicated they had applied the only dressing they could find. The DOC indicated it was an inappropriate dressing. All PSWs denied seeing or being aware of the resident's altered skin prior to RPN #110's discovery. The DOC indicated the long-term care home had supplies available for the appropriate treatment.

The DOC indicated a Skin and Wound referral was expected to be sent to the Wound Care Champion (WCC) with any new, worsening wounds and as needed for support. The WCC role was to ensure the appropriate treatment and interventions to

promote healing. Staff were to document in the e-TAR any new treatments.

RPN #111 applied the incorrect dressing and did not report or document the resident's altered skin integrity.

RPN #110 discovered the resident's wound approximately a week after RPN #111, and the resident's wound required a different dressing and an oral antibiotic.

By failing to ensure the resident received immediate treatment and interventions to promote healing and prevent infection caused to the resident's wound to worsen.

Sources: A CIR, a resident's clinical records, and an interview.

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to immediately notify the police of an alleged incident of misuse or misappropriation of residents' money.

Rationale and Summary

A CIR was submitted to the Director regarding an alleged incident of misuse or misappropriation of residents' money involving a resident. The CIR did not indicate

that the police were notified of the allegation.

The DOC and ADOC both indicated that the police were not notified of the allegation.

Failure to immediately notify the police of an allegation of misuse or misappropriation of money involving a resident delayed an investigation by local authorities and placed the resident at risk of further incidents of misuse or misappropriation of residents' money.

Sources: A CIR and interviews.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 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 failed to ensure that a resident was administered a drug in accordance with the directions for use specified by the prescriber.

Rationale and Summary

Review of daily audits for Compliance Order #013 from inspection #2023-1200-0003 identified medication incidents occurred involving a resident.

A record review of a resident's electronic medication administration records (e-MAR)

was completed. A resident's medication was held by an RPN on a few days, for a specified reason. The ADOC indicated the medication that was held by the RPN should have been administered to the resident unless they received an order to hold the medication from a physician.

The ADOC confirmed not providing the medication without a physician direction would be considered a medication incident.

Sources: A resident's clinical records, Compliance Order #013 from inspection #2023-1200-0003 records from the long-term care home, and an interview.

2) The licensee failed to ensure that a resident was administered a drug in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A complaint was submitted to the Director alleging improper administration of medication.

The resident's e-MAR directed to not crush a delayed release medication tablet. The RPN indicated they crushed the resident's medication and administered them in pudding.

By failing to administer drugs as prescribed, the resident was at risk of adverse reaction or ineffective results of medication.

Sources: A resident's e-MAR, and an interview.

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) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee shall ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the wellbeing of the resident.

Rationale and Summary

A resident's medication was held by two RPNs on different days without a physician order. The progress notes indicated the resident's medication was held for a specified reason. The ADOC indicated that the medication should not be held without a physician order.

There was no medication incident report for the omission errors.

By failing to ensure a resident's medication errors were documented together with a record of the immediate actions taken to assess and maintain the wellbeing of resident put the resident at risk of unidentified health status change.

Sources: A resident's clinical record, Compliance Order #013 records from Inspection #2023-1200-0003, and an interview.

WRITTEN NOTIFICATION: Police record check is required before hiring

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (1)
Hiring staff, accepting volunteers
s. 252 (1) This section applies where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.

The licensee failed to ensure a police record check was completed before the licensee hired a PSW.

Rational and Summary

A CIR was submitted to the Director for an alleged staff-to-resident verbal abuse that happened between a PSW and a resident.

Personnel files related to a PSW's qualifications and police checks were reviewed. Documentation review identified the PSW was hired and had worked in the home for a few years. Documentation failed to identify that the licensee had obtained a police check including a vulnerable sector screening for the PSW.

The Executive Director (ED) indicated that all staff hired must have a vulnerable sector check (Police record check) on file, but a Police record check for the PSW was not found in their records.

Failure to obtain a police record check for the PSW posed a risk of unsafe interaction with the resident and the resident's rights to be protected from abuse and neglect.

Sources: A CIR, an employee file, and an interview.

WRITTEN NOTIFICATION: Guidance issued by the CMOH

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that a guidance document issued by the Chief Medical Office of Health, was followed specifically ensuring that the Alcohol based hand rub (ABHR) was not expired.

In accordance with, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, April 2024, ABHR was not to be expired.

Rationale and Summary

During a tour of the home expired Alcohol Based Hand Rub (ABHR) was observed in two resident common areas.

The IPAC lead confirmed that the identified ABHR in use for the two resident common areas were expired.

Failing to ensure that the home's ABHR was not expired, increased the potential for spread of infection in the home.

Sources: Observations during the tour of the home and an interview.

COMPLIANCE ORDER CO #001 SKIN AND WOUND CARE

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

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

1) The Skin and Wound Care Lead and the Physiotherapist or designate shall prepare a list of residents who are using a specified mobility device and who are dependent on staff for repositioning while using the mobility device.

2) The Physiotherapist and the Occupational Therapist or designate shall assess each resident included in the list as identified in requirement #1 of this compliance order to ensure each resident is using a properly fitted specified mobility device to reduce and prevent skin breakdown and reduce and relieve pressure.

3) The DOC or designate shall review and update the plan of care of each resident

identified in requirement #1 of this compliance order to identify that the resident is assessed for seating and positioning in using their specified mobility device and determine the frequency of repositioning while the resident is using their mobility device. Keep a record of who participated in the review and who updated the plans of care.

4) The DOC or designate shall ensure residents are assessed within one week of initiating referrals for seating assessments for pressure relief while taking necessary measures to reduce any risk of skin integrity until an assessment is completed and the risk is reduced.

5) The DOC or designate shall provide training to all registered staff including Agency registered staff on the home's process of communicating and initiating referrals to the Physiotherapist and or Occupational Therapist.

Grounds
The licensee has failed to ensure a resident received an appropriate mobility device to reduce and prevent skin breakdown and reduce and relieve pressure.

Rationale and Summary

A CIR was submitted to the Director regarding improper/incompetent treatment of a resident that resulted in harm or risk to the resident. The CIR indicated that a resident's substitute decision-maker (SDM) had multiple concerns related to the care of the resident's wounds.

The resident's SDM provided a mobility device for the resident and there was no record that an assessment was completed to determine if the mobility device was an appropriate fit for the resident.

The resident developed areas of altered skin integrity, and the resident had a few

areas of skin integrity that had deteriorated.

The WCC assessed the resident's wounds and noted that the positioning of the resident in their mobility device was causing increased friction and pressure to the one of the areas where the resident's wound had deteriorated. The Occupational Therapy (OT) skin and wound referral that was sent to determine appropriate positioning and pressure relief was not completed.

The physician documented that the resident had developed wounds and needed more positional changes throughout the day. The resident needed to have their mobility device re-assessed to make sure it was the right size for the resident.

Physiotherapist #115 assessed the resident and determined the resident required a new mobility device several weeks after the resident developed pressure related wounds.

Failing to assess the resident for a properly fitted mobility device when the resident presented with signs of pressure areas could have put the resident at increased risk of developing altered skin integrity and delayed healing.

Sources: A CIR, a resident's health records and interviews.

This order must be complied with by February 14, 2025

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Follow-up #2 - CO #013 / 2023-1200-0003, O. Reg 246/22 s. 140 (2) Administration of drugs, CDD March 31, 2024, RIF $500 Refer to notes section - WN-25507. Report meeting July 10, 2024, with Caressant Care Lindsay for CO #013, WN #009 under inspection #2024-1200-0001, order #4 and #5 that was not complied, this CO will be for all diabetic residents that are insulin dependent, the DOC will audit to ensure all insulin diabetic residents are given their medication as prescribed.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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.