Ontario

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

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

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

Original Public Report

Report Issue Date: January 12, 2024

Inspection Number: 2023-1400-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay

Lead Inspector	**Inspector Digital Signature**
Laura Crocker (741753)	Laura L Crocker Digitally signed by Laura L Crocker Date: 2024.01.25 08:39:43 -05'00'

Additional Inspector(s)
Jennifer Batten (672)
Patricia Mata (571)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00091558 -Complaint related to multiple concerns related to a resident's plan of care,
- Intake: #00092049 - Follow-up #:2- High Priority, CO# 009/ 2023_1400_0003. O. Reg. 246/22 - s. 257 (1), Training and Orientation, CDD Oct 4, 2023, RIF $500

- Intake: #00092050 - Follow-up #1 – WN #016, High Priority Compliance Order #002 / 2023_1400_0003, O. Reg. 246/22, s. 55 (2) (b) (i) regarding skin and wound, CDD October 4, 2023.
- Intake: #00092051 - Follow-up #1 – WN #017, High Priority Compliance Order #003, O. Reg. 246/22 - s. 55 (2) (b) (iv) regarding skin and wound, CDD October 4, 2023.
- Intake: #00092052 - Follow-up #2, WN #008 FLTCA, 2021, s. 104 (4) / 2023_1400_0003, regarding O. Reg. 246/22, s. 140 (2) medication administration, CDD October 4, 2023, RIF $500.
- Intake: #00092053 - Follow-up #2, WN #007 FLTCA, 2021, s. 104 (4) / 2023_1400_0003, regarding High Priority Compliance Order #005, O. Reg. 246/22, s. 147 (1)(b), medication incidents from inspection #2022_1400_002 with a CDD of January 20, 2023, RIF $500.
- Intake: #00092054 - Follow-up #2 - WN #006 FLTCA, 2021, s. 104 (4) / 2023_1400_0003, regarding High Priority Compliance Order #006, O. Reg. 246/22 - s. 123 (2), medication management from inspection #2022_1400_002 with an extended CDD of February 8, 2023, RIF $500.
- Intake: #00092055 - Follow-up #1 – WN #022, Compliance Order #008 / 2023_1400-0003 FLTCA, 2021, s. 6 (1) (c) regarding plan of care, CDD October 4, 2023.
- Intake: #00092056 - Follow-up #1 – WN #015, High Priority Compliance Order #001, O. Reg. 246/22 - s. 34 (1) 2 regarding general requirements, CDD October 4, 2023.
- Intake: #00092057 - Follow-up #1 - WN #024, Compliance Order #010, O. Reg. 246/22, s. 41 (1) (a) / 2023_1400_0003 regarding personal items and personal aids, CDD October 4, 2023.
- Intake: #00092058 - Follow-up #1 – WN #018, Compliance Order #004, O. Reg. 246/22 - s. 57 (2) / 2023_1400_0003 regarding pain management, CDD October 4, 2023.

- Intake: #00092059 - Follow-up #1 – WN #020, High Priority Compliance Order #006, O. Reg. 246/22, s. 79 (1) 9 / 2023_1400_0003 regarding dining and snack service, CDD October 4, 2023.
- Intake: #00092060 - Follow-up #1 – WN #021, High Priority Compliance Order #007, O. Reg. 246/22 - s. 95 (1) (a) (iv) / 2023_1400_0003 regarding laundry service, CDD October 4, 2023.
- Intake: #00092061 - Follow-up #1 – WN #025, Compliance Order #011, O. Reg. 246/22 - s. 79 (2) (b) / 2023_1400_0003 regarding dining and snack service, CDD October 4, 2023.
- Intake: #00092062 - Follow-up #1 – WN #019, High Priority Compliance Order #005, O. Reg. 246/22, s. 79 (1) 4 / 2023_1400_0003 regarding dining and snack service, CDD October 4, 2023.
- Intake: #00092063 - Follow-up #1 – WN #027, Compliance Order #013, O. Reg. 246/22, s. 138 (1) (a) (ii) / 2023_1400_0003 regarding medication, CDD October 4, 2023.
- Intake: #00092064 - Follow-up # 1, WN #26, Compliance Order #012/ 2023_1400_0003, O. Reg. 246/22 - s. 102 (2) (b), regarding IPAC, CDD Oct 4, 2023.
- Intake: #00092065 - Follow-up #1 – WN #023, Compliance Order #014, O. Reg. 246/22 - s. 147 (1) (a) / 2023_1400_0003 regarding medication incidents, CDD October 4, 2023.
- Intake: #00092066 - Follow-up #1 – WN #029, Compliance Order #015, O. Reg. 246/22, s. 147 (2) (b) /2023_1400_0003 regarding medication incidents, CDD October 4, 2023.
- Intake: #00092067 - Follow-up #1 – WN #023, Compliance Order #009, O. Reg. 246/22 - s. 37 (1) / 2023_1400_0003 regarding bathing, CDD October 4, 2023.
- Intake: #00097989 - Follow -up #3, WN #002, Compliance Order #002, O, Reg. 79/10- s. 135. (1)(a) /#2022_861194_0005, regarding medication, CDD July 10, 2022.

- Intake: #00097994 - Follow-up #3, WN #002, Compliance Order #004, O. Reg. 79/10, s. 135. (2)(b), / #2022_861194_0005, regarding medication incidents, CDD July 10, 2022.
- Intake: #00098009 - Follow-up #3, WN #003, Compliance Order #006 O. Reg 79/10- s. 33 (1), #2022_861194_0005, regarding bathing preferences, CDD June 15, 2022.
- Intake: #00098794 - CI: related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #009 from Inspection #2022-1400-0002 related to O. Reg. 246/22, s. 257 (1) inspected by Laura Crocker (741753)

Order #002 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 55 (2) (b) (i) inspected by Patricia Mata (571)

Order #003 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Patricia Mata (571)

Order #004 from Inspection #2022-1400-0002 related to O. Reg. 246/22, s. 140 (2) inspected by Patricia Mata (571)

Order #005 from Inspection #2022-1400-0002 related to O. Reg. 246/22, s. 147 (1) (b) inspected by Patricia Mata (571)

Order #006 from Inspection #2022-1400-0002 related to O. Reg. 246/22, s. 123 (2) inspected by Patricia Mata (571)

Order #008 from Inspection #2023-1400-0003 related to FLTCA, 2021, s. 6 (1) (c) inspected by Jennifer Batten (672)

Order #010 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 41 (1) (a) inspected by Jennifer Batten (672)

Order #004 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 57 (2) inspected by Jennifer Batten (672)

Order #006 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 79 (1) 9. inspected by Jennifer Batten (672)

Order #007 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 95 (1) (a) (iv) inspected by Jennifer Batten (672)

Order #011 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 79 (2) (b) inspected by Jennifer Batten (672)

Order #005 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 79 (1) 4. inspected by Jennifer Batten (672)

Order #013 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 138 (1) (a) (ii) inspected by Laura Crocker (741753)

Order #012 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Laura Crocker (741753)

Order #014 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 147 (1) (a) inspected by Patricia Mata (571)

Order #015 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 147 (2) (b) inspected by Patricia Mata (571)

Order #009 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 37 (1) inspected by Laura Crocker (741753)

Order #002 from Inspection #2022_861194_0005, related to O. Reg 79/10, s. 135 (1) (a) inspected by Patricia Mata (571)

Order #004 from Inspection #2022_861194_0005, related to O. Reg 79/10, s. 135 (2) (b) inspected by Patricia Mata (571)

Order #006 from Inspection #2022_861194_0005 related to O. Reg. 79/10, s. 33 (1) inspected by Laura Crocker (741753)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1400-0003 related to O. Reg. 246/22, s. 34 (1) 2. inspected by Jennifer Batten (672)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Pain 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 (4) (a)
Plan of care
Integration of assessments, care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others collaborated in the assessment of a resident so the assessments were integrated, consistent with and complemented each other.

Rationale and Summary
A complaint was submitted to the Director by a family member indicating they reported to the nurse a health concern for a resident. The nurse wrote down their concern in the Physician's binder to assess the resident. Weeks later the family member reported they made a visit to the home and the resident had the same health condition. The nurse reported to the family member no treatment was ordered by the Physician. That same day the nurse called the Physician, and the Physician prescribed treatment for the resident's health condition.

The Registered Practical Nurse reported, the complainant reported to them their concern regarding the resident's health condition. The RPN reported they told the complainant they would update the Physician's binder, for them to assess the resident on their next visit, the following week. The RPN reported the process when

the Physician came to the home was the Physician would assess resident concerns noted in the Physician binder, and then put a line through the doctor's sheet in the binder, indicating they had read the nurses assessment.

The RPN reported weeks later the complainant enquired if the Physician had prescribed any treatment for the resident. The RPN indicated they looked at the doctor's sheet and a line had been crossed through the nursing assessment. The RPN indicated they further reviewed the Physician's order sheet and noted nothing had been prescribed to treat the resident's health condition. The RPN reported they called the Physician. The Physician having learned there was no treatment ordered, prescribed a medication to treat the resident's health condition.

The resident's health records indicated there was no documentation by the nursing staff or the Physician indicating the resident's health condition had been assessed by staff. The RPN documented they called the Physician regarding the resident's health condition weeks later, when the resident's family member brought it to their attention. A week after starting treatment the resident's health condition was healed.

The RPN acknowledged a documented note by the Physician should have been written in the resident's health record indicating they had assessed the resident, on their scheduled physician day. The RPN further acknowledged the nursing staff should have written in the health record indicating the resident had a health concern, the assessment, and what follow up was being done with the Physician, The RPN agreed the nursing staff and Physician should have collaborated better, and the health care team should have followed up prior to the family readdressing the resident's health condition weeks later.

The DOC acknowledged the nursing staff and Physician should have assessed and documented the resident's health condition. The DOC agreed the nursing staff should have continued to follow up with the Physician on their follow up visits to the

home when the resident's health condition did not heal, and the nurse and Physician should have collaborated better.

Failure to ensure integrated assessments of the resident so that they were consistent with and complemented each other may have put the resident's health at an increased risk.

Sources: Resident's health records, doctor's sheet, digital prescriber's orders, interviews with staff and the DOC. [741753]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that when the resident's care needs changed the care plan was reviewed and revised.

Rationale and Summary
A complaint was submitted to the Director by a resident's family member indicating a care concern for a resident. The complaint indicated they were told hand hygiene interventions were put in place however concerns regarding the resident's hand hygiene remained.

The resident's records indicated the Executive Director (ED) spoke to the complainant, and they voiced a concern regarding the resident's hands hygiene. The ED indicated they would investigate.

The Vice President (VP) of PrimaCare reported they had received an email from the resident's family member indicating a concern about the resident's hand hygiene. The VP confirmed a Critical Incident Report (CIR) was submitted regarding this concern. The VP of PrimaCare reported there were interventions to address the resident's hand hygiene, which included personal care on bath days and staff providing hand hygiene when the resident's hands required. The VP of PrimaCare reported the staff was looking at further interventions to implement, one of those interventions included adding it to the electronic medication record (E-mar).

The resident electronic medication record (E-mar) and care plan was reviewed. The E-mar did not direct staff to assess the resident's hand hygiene daily. The resident's care plan indicated to ensure the hand hygiene was provided on bath days.

A CIR submitted by the home indicated a resident's family member had sent an email to the home regarding concerns about a resident's personal care. One of their concerns indicated they had provided the resident hand hygiene again.

During the inspection the resident's hand hygiene was observed. The resident required hand hygiene. The PSW agreed with the inspector the resident needed hand hygiene. The PSW indicated the interventions was to continuously look at the residents hands.

The Director of Care (DOC) was aware of the observation of the resident's hands with the PSW. The DOC reported the interventions included hand hygiene at mealtime and then in the morning and evening with care. The DOC agreed the plan of care had not been updated to include this direction to staff.

The resident is at an increased risk for infection when their hands are not kept clean by staff.

Sources: CIR, observations, a resident's health records, interviews with staff, the DOC, and the VP of PrimaCare. [741753]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licensee
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licensee is subject.

The licensee has failed to comply with Compliance Order (CO) #001 from inspection #2023_1400_0003, regarding O. Reg. 246/22, s. 34 (1) 2, served on July 10, 2023, with a compliance due date of October 4, 2023.

Specifically, the licensee did not ensure a that resident's personal device was appropriate for the resident, as it was not based on the resident's current physical condition.

Rationale and Summary
A Resident was observed to be in the same personal mobility device they were utilizing during the previous inspection. Multiple observations of the resident during meals throughout the inspection showed that the resident continued to have concerns regarding their positioning in their personal mobility device. Review of the resident's health care record indicated the resident was noted to have sustained falls from the personal assistive device along with several instances when the resident was noted to be sliding from the personal assistive device. Due to this, the

resident was often repositioned by staff in an attempt to prevent further falls and/or to keep the resident safe and comfortable. The resident was noted to exhibit responsive behaviours when they needed to be repositioned while in the personal assistive device, and experienced an incident where they sustained an injury while being repositioned. PSW staff indicated to the Inspector that the resident's personal assistive device continued to not be appropriate for the resident, as it was not based on the resident's current physical condition.

Sources: Observations, review of a resident's health records, interview with staff, and the Vice President of Prima Care. [672]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #003

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 an order under s. 155 of the Act.

Compliance History:
There was a previous CO issued under s. 34 (1)2 during inspection #2023_1400_0003, issued on July 10, 2023 with a CDD of August 22, 2023

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.

WRITTEN NOTIFICATION: MENU PLANNING

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;

The licensee failed to ensure a resident was offered a minimum of three meals daily.

Rationale and Summary
During a meal observation, a family member asked to speak to the Inspector. The resident was observed eating dessert. The family member reported the resident had not received a meal. PSW #119 and the ESM who were assisting and/or supervising in the dining room indicated the resident had been served and consumed their meal prior to receiving the dessert. PSW #119 then approached PSW #122, as they indicated that staff member had served meals to the resident's dining table. PSW #122 indicated they had not served a meal to the resident as they had believed someone else was going to. Once PSW #119 learned the resident had not received a meal, they approached the kitchenette and attempted to order a meal for the

resident, but the meal service had completed, and dietary staff were in the process of cleaning up. The dietary aide indicated no meals were available, but they would provide the resident with an alternative, some toast and jam. The resident and their family member were offered the alternative and the resident accepted the alternative as their meal replacement. The PSW, dietary and management staff supervising in the dining room were aware of the situation and they did not attempt to contact another kitchenette or the main kitchen to assess if a meal was available for the resident to consume.

By not ensuring the resident was offered a minimum of three meals daily, they were placed at risk of not having their dietary and/or caloric needs met, not enjoying the dining experience and of possibly sustaining unwanted weight loss.

Sources: Observations, review of the resident's health records review, interviews with the resident, the family member, staff, and the ESM. [672]

COMPLIANCE ORDER CO #001 Medication incidents and adverse drug reactions

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2)
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;
(b) corrective action is taken as necessary; and

(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

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

The licensee shall:

1) Ensure 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 reviewed, analyzed and corrective action taken as necessary, once per month for two months.

2) Develop and implement a process that directs who is primarily responsible for the review and follow-up of each individual medication incident as they occur; and who is responsible for the review, analysis and corrective action taken for all medication incidents. Ensure there is a backup person responsible for when the primary is absent from the home.

3) Keep a written record of the monthly review, analysis and corrective action taken. Include dates of the review, analysis and corrective action, and the person who completed this.

4) Ensure the review, analysis and corrective action taken, are discussed with the Professional Advisory Committee at quarterly meetings. Only disclose resident personal health information, staff involved and disciplinary action at these meetings as per the licensee's policies and existing privacy laws.

5) Records of every medication incident documented, together with a record of the immediate actions taken to assess and maintain the resident's health are to be provided to the inspector immediately upon request. Ensure records include details of medication error, and the residents' and staff members involved full names.

6) Records of the review, analysis and corrective action taken are to be provided to the inspector immediately upon request.

Grounds
The licensee failed to 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; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b).

Rationale and Summary
The licensee's medication incident binder was reviewed for a five month period. Numerous medication incidents were identified during this time. Included in front of the binder were forms. The forms included details of the medication incidents that occurred, remedial action taken and a cause analysis. Directions on the form indicated that medication error audits were to be reviewed, the manager was to document the details that lead to the medication incident and the actions taken to prevent errors from reoccurring.

The Nurse Consultant reported they completed the analysis and action form for medication incidents for the five-month period. The review, of the medication incident forms were not completed until after this five-month period.

By failing to ensure all medication incidents were reviewed, analyzed, corrective action taken as necessary, and a written record kept, the licensee put the residents at risk of reoccurring medication incidents.

Sources: Review of the medication incident binder and interview with the Nurse Consultant. [571]

This order must be complied with by April 15, 2024

COMPLIANCE ORDER CO #002 Communication and response system

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

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

1) Management of the home is to conduct daily audits for a period of two weeks and then twice weekly audits for a period of two weeks, at times when the residents are present in their bedrooms, to ensure call bells are accessible as required for five particular residents. Audits are to include the name of the person who completed and date of the audit, any findings of noncompliance and the corrective measures taken to correct the noncompliance.

2) Keep a documented record of the audits completed and make immediately available to Inspectors upon request.

Grounds
The licensee has failed to ensure that five resident's had a communication system which was accessible to them at all times.

Rationale and Summary
Observation of the internal communication system within the home during tours of each of the resident home areas. Residents were observed in their bedrooms but were not noted to have access to their call bells. The call bells were located out of

reach for five residents, as the call bells were noted to be in the top drawer of the bedside tables, tucked under pillows, left on the floor and/or behind beds.

During separate interviews, two resident's indicated the call bell was usually left out of their reach therefore they would just call out to the staff in the hallway whenever they saw or heard someone passing by when they required assistance. Two different resident's indicated they were unsure of how they would reach out to staff if assistance was required and one resident did not indicate how they would contact staff for assistance. Interviews with three PSWs, the DOC and the Vice President for Prima Care indicated the expectation in the home was for staff to always ensure call bells were within reach for residents to utilize as required.

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

Sources: Observations, review of the resident's health records, interviews with residents, staff, the DOC and the Vice President for Prima Care. [672]

This order must be complied with by February 29, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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.