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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 3, 2024

Inspection Number: 2024-1536-0003

Inspection Type:
Complaint
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Castleview Wychwood Towers, Toronto

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2024.06.13 10:52:59 -04'00'

Additional Inspector(s)
Noreen Frederick (704758)
Goldie Acai (741521)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2024 and May 1, 2, 3, 6, 7, 8, 9, 10, 13, 2024

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00109155/CIS#M510-000011-24 was related to physical abuse resulting in injury.
- Intake: #00109396/CIS#M510-000014-24 was related to a resident's fall.
- Intake: #00110790/CIS#M510-000016-24 was related to physical abuse resulting in a fall with fracture.

- Intake: #00112057/CIS#M510-000018-24 was related to physical abuse resulting in a fall with injuries.
- Intake: #00113476/CIS#M510-000023-24 was related to a disease outbreak.

The following intakes were inspected in the Complaint Inspection:

- Intake: #00109082 was related to a resident's care.
- Intake: #00109137 was related to responsive behaviours, dealing with complaint process, home to be safe, secure environment, reporting certain matters to director, and potential abuse.
- Intake: #00109156 was related to a resident's abuse.
- Intake: #00114265 was related to bed refusal.

The following intake was completed in the CIS Inspection:

- Intake: #00110330/CIS#M510-000015-24 was related to a disease outbreak.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care sets out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
Review of the resident's care plan indicated they required a specific intervention related to responsive behaviours. However, the care plan did not specify how frequently the intervention had to be implemented by staff.

A Personal Support Worker (PSW) stated they don't have any specific schedule to follow to implement the intervention. A Registered Nurse (RN) acknowledged that the resident's written plan of care should have included a schedule for staff to follow to implement the specific intervention, and it was not specified in the plan. The Acting Director of Nursing (ADON) acknowledged that the resident's written plan of care did not provide clear/specific directions to staff for the implementation

of the specific intervention for the resident.

Failure to ensure the written plan of care for the resident sets out clear directions to staff poses gaps in services afforded to the resident.

On May 10, 2023, the RN modified the resident's care plan to add a specific schedule for staff to follow.

Sources: Resident's clinical records, interviews with PSW, RN, and ADON. [741673]

Date Remedy Implemented: May 10, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the planned care for a resident was included in resident's written plan of care.

Rationale and Summary
A resident had weakness due to an identified health condition. An Occupational Therapist's (OT) assessment revealed that the resident had limited voluntary

movement and experienced pain with passive range of motion. Additionally, due to weakness they wore a specific device. This intervention was not found in the resident's written care plan. A complaint to the Long-Term Care Home (LTCH) requested the home to ensure that utensils were provided to the resident on their specific side, and for this intervention to be reflected on their written care plan which was not done.

The RN confirmed that the planned care for both interventions were not in the written plan of care and the ADON acknowledged that staff were expected to update the written plan with the resident's interventions.

Failure to update the resident's written plan of care, increased the risk of staff not becoming aware of the interventions related to their care.

Sources: Resident's care plan, family member complaint email, and interviews with RN and ADON.
[704758]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 and resident #011 as specified in the plan.

Rationale and Summary

i) Resident #003's written plan of care indicated that the resident received a specific incontinence care routine. The PSW stated that on an identified date, they did not offer the specific incontinence care routine to the resident at a specific time, and each time they worked they did not offer the resident the incontinence care routine at a specific time. They acknowledged that they did not comply with the resident's plan of care. The ADON acknowledged that staff were expected to provide care to the resident as indicated in their plan of care.

Failure to ensure that resident #003 was provided with care as set out in their plan of care, placed resident at risk of not having their needs met.

Sources: Resident #003's care plan, interviews with PSW, and ADON.
[704758]

Rationale and Summary

ii) Resident #011 was observed performing an Activity of Daily Living (ADL) task by themselves without staff assistance, while the PSW observed and provided support to the resident from outside. Resident #011's care plan indicated that the resident required specific staff assistance for the ADL task, however, the PSW confirmed resident #011 was able to perform the task without specific staff assistance. Registered Practical Nurse (RPN) confirmed the plan of care for resident #011 stated that the resident require specific staff assistance due to their responsive behaviours, and specific staff assistance was initiated as a safety measure, thus, there should always be specific staff providing assistance to the resident.

Failure to ensure that the care set out in the plan of care was provided to resident #011 as specified in the plan increased safety risks to both resident and staff during care to resident.

Sources: Interview with PSW and RPN, observation of resident #011; and record review of the resident's care plan.
[741521]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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 has failed to ensure that the resident was reassessed and the plan of care reviewed when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary
A resident was observed sitting in the dining area drinking and eating their meal without assistance. The resident was not observed with any physical limitation while eating. The resident's plan of care stated that they required specific assistance during meals. The PSW confirmed that the resident could now eat without assistance. The RPN confirmed the resident did not require assistance and was able to eat with supervision. Thus, the written plan of care should have been updated to reflect the changes in the resident's care needs.

Failure to ensure the resident was reassessed, and the plan of care reviewed when the resident's care needs changed, or care set out in the plan was no longer necessary increased the risk of triggering the resident's behaviours.

Sources: Interview with PSW and RPN, observation of the resident; and record review of the resident's care plan.
[741521]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint received concerning the care of residents #002 and #003.

Rational and Summary
i) A complaint was received by the home from resident #002's family regarding their care.

The Nurse Manager (NM) stated the email complaint was not submitted to the Director because the email was not viewed as a complaint at the time it was received. The NM and ADON, both confirmed the email was a complaint and should have been submitted to the Director, and that the home failed to do so. The CIS portal indicated that no critical incident had been submitted related to the written complaint.

Failure to forward to the Director any written complaint that the home received concerning the care of a resident may delay the Director's response to follow-up.

Sources: Interviews with NM, ADON, and review of LTCH Portal CIS on ltchomes.net.
[741521]

Rationale and Summary
ii) The Ministry of Long-Term Care (MLTC) received a written complaint regarding multiple concerns related to a resident's care. The complainant had communicated the above-mentioned concerns via email to the home's management. The complainant indicated that the home had responded to some of the expressed concerns but not all and resident #003 continued to experienced care issues.

The ADON acknowledged that an email related to resident #003's care concerns had been received by the home and those concerns were not forwarded to the Director.

Failure to forward the written complaint concerning the care of resident #003 to the Director could result in improper follow up to the complaint.

Sources: Review of the complaint to MLTC, and interviews with the complainant and ADON.
[704758]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident had occurred or may occurred, they immediately reported the suspicion to the Director.

Rationale and Summary
A incident between two residents resulted in one of them falling and sustaining an injury. The home was aware of this incident of abuse, however they failed to immediately call the afterhours action line to report the incident to the ministry. The report was submitted the following day to the ministry. The ADON, and RN both confirmed that the afterhours reporting line should have been used to immediately inform the ministry of this incident of resident-to-resident abuse.

Failure to immediately report any suspected abuse to the Director, increases the risk of a delay of appropriate follow-up.

Sources: Interviews with the ADON and RN, record review of two resident's charts, progress notes, and care plan.
[741521]

WRITTEN NOTIFICATION: Licensee consideration and approval

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)

Authorization for admission to a home
s. 51 (7) The appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to comply with FLTCA s. 51 (7) (b) whereby the licensee refused an applicant's admission to the home based on reasons that were not permitted in the legislation.

Specifically, the licensee withheld the approval for the admission citing the staff of the home lacked the nursing expertise.

Rationale and Summary
The MLTC received a complaint related to withholding an applicant's admission.

The LTCH withheld the applicant's approval for admission due to specific care requirements.

A written refusal letter cited that staff of the home lacked the nursing expertise necessary to meet the applicant's responsive behaviour care needs, due to their current responsive behaviour caseload and other specific care requirements.

The NM stated the home had a Behavioural Supports Ontario (BSO) program, external resources to assist residents with responsive behaviours, and staff of the home were trained in the areas of responsive behaviours management. They also

stated that the home did not have a set number or a CAP on the number of residents with responsive behaviour who can be accommodated in the home at one time. Additionally, the home did not have a policy related to responsive behaviour caseload. They also stated that based on the LTCH's smoking policy and application information received from Home and Community Care Support Services (HCCSS), the applicant could have been admitted to the home as they met the criteria.

The NM was unable to provide sufficient information to substantiate the specific nursing expertise which staff at the home required to meet the applicant's needs. The Administrator acknowledged the same.

There was a moderate impact to the applicant, when the home withheld their approval for admission without the appropriate grounds, as the applicant was not able to transition to the LTCH that was their choice. This posed a potential risk of the applicant not receiving the care and support they needed.

Sources: An applicant's application for admission to LTCH, including assessments, refusal letter, and interviews with the NM and the Administrator.
[704758]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (b)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;

The licensee has failed to ensure that when the home withheld approval for admission, they gave the applicant a written notice setting out a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care.

Rationale and Summary
A written refusal letter cited that staff of the home lacked the nursing expertise necessary to meet the applicant's responsive behaviour care needs, due to their current responsive behaviours caseload and other specific care requirements.

This written refusal letter failed to provide a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care identified on the applicant's admission package. The NM and the Administrator both acknowledged the same.

As such, the written notice sent to the applicant and the placement coordinator by the home failed to meet the requirements of this provision.

Sources: The written refusal letter, interviews with NM and the Administrator. [704758]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (c)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to

persons described in subsection (10) a written notice setting out,
(c) an explanation of how the supporting facts justify the decision to withhold approval; and

The licensee has failed to ensure that when the home withheld approval for admission, that they provided the applicant and the placement coordinator with a written notice setting out an explanation of how the supporting facts justified the decision to withheld approval.

Rationale and Summary
A written refusal letter cited that staff of the home lacked the nursing expertise necessary to meet the applicant's responsive behaviour care needs, due to their current responsive behaviours caseload and other specific care requirements.

This written refusal letter failed to provide an explanation of how the supporting facts substantiated the home's decision to withhold approval. The NM and the Administrator both acknowledged the same.

As such, the written notice sent to the applicant and the placement coordinator by the home failed to meet the requirements of this provision.

Sources: The written refusal letter, and interviews with NM and the Administrator. [704758]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home

s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

The licensee has failed to ensure that when the home withheld approval for admission, that they provided the applicant and the placement coordinator with a written notice setting out contact information for the Director.

Rationale and Summary
A written refusal letter cited that staff of the home lacked the nursing expertise necessary to meet the applicant's responsive behaviour care needs, due to their current responsive behaviours caseload and other specific care requirements.

This written refusal letter failed to include contact information for the Director. The NM and the Administrator both acknowledged the same.

As such, the written notice sent to the applicant and the placement coordinator by the home failed to meet the requirements of this provision.

Sources: The written refusal letter, and interviews with NM and the Administrator. [704758]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 3.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum,

provide for the following:
3. Toileting programs, including protocols for bowel management.

The licensee has failed to ensure that a continence care and bowel management program including protocols for bowel movement was implemented.

In accordance with O. Reg 246/22, 11 (1) (b), the licensee was required to ensure a continence care and bowel management program to promote continence was implemented and was complied with.

Specifically, the LTCH did not comply with their policy "Medical Bowel Protocol" RC-0525-03, published on January 07, 2019.

Rationale and Summary
The MLTC received a complaint related to several care concerns including continence care. The LTCH's three-step clinical bowel protocol required a nurse to administer specific medication at bedtime if a resident did not have a bowel movement on the third calendar day. Review of the resident's clinical record revealed that they had three incidents where the bowel protocol was not implemented. The RN reviewed the same records and stated that bowel protocol was not implemented on all three incidences.

The ADON acknowledged that staff were expected to implement the bowel protocol when the resident did not have a bowel movement for three calendar days.

Failure to implement the bowel protocol, increased the risk of residents not receiving interventions to prevent constipation.

Sources: Resident's clinical records, LTCH's policy "Medical Bowel Protocol" RC-0525-03, published on January 07, 2019, Interviews with RN and the ADON. [704758]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

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

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically, Section 9.1, "the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program", including the four moments of hand hygiene and Section 7.3, "the licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and ensures that audits were performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

Rationale and Summary

i) During a dining service on a home area, the PSW was observed portering a wheelchair-dependent resident to the dining room for a meal service. After seating the resident at their designated table, the PSW went to another resident and began feeding them. The PSW failed to perform hand hygiene after the first resident's contact and prior to initiating feeding for another resident.

The home's policy titled "Hand Hygiene" indicated hand hygiene should be performed before/after contact with resident/client and touching furniture/equipment in the resident/client environment.

The PSW stated that they might have missed hand hygiene in-between assisting residents in the dining room. The IPAC Lead acknowledged that staff did not implement appropriate hand hygiene practice.

Failure to ensure hand hygiene was performed according to routine practices increased the risk of infectious disease transmission.

Sources: Dining observation, IPAC Standard for LTCH's last revised September 2023, home's hand hygiene policy #IC-0606-01 dated January 2021, interviews with PSW and IPAC lead.

Rationale and Summary
ii) The home's IPAC audits revealed that specific IPAC practice audits were not performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

The IPAC Lead acknowledged that the IPAC audits to ensure all employees were capable of carrying out the IPAC skills necessary for their roles were not completed. They stated that the required auditing process to check the IPAC competency for all staff were not developed in the home and the licensee was in process of developing these audits.

Failure to conduct IPAC practice audits increased the risk of staff not adhering to proper infection control protocols, leading to the spread of infectious diseases

among residents and staff members.

Sources: IPAC Standard for LTCH's last revised April 2022, Home's IPAC audits and interview with IPAC lead.
(741673)

WRITTEN NOTIFICATION: Dealing with complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;

The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint.

Rationale and Summary
The MLTC received a complaint regarding ongoing concerns related to a resident's care. The complainant had communicated concerns via email to the home's management. The LTCH was unable to provide the documented record of this complaint.

During an interview with the complainant, they stated their concerns had not been adequately addressed by the home's management.

The home's "Managing and Reporting Complaints" policy stated the home must keep a documented record about all complaints received unless the complaints

were not reportable and that the licensee was able to resolve within 24 hours.

The ADON stated the compliant was not documented.

The home's failure to keep a documented record of the complaints received, poses a risk for the concerns not being followed up and resolved promptly.

Sources: Review of the complaint to MLTC, LTCH's "Managing and Reporting Complaints" policy AD-0515-00 published on January 07, 2022, and interview with the ADON.
[704758]

COMPLIANCE ORDER CO #001 Duty to protect

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 24 (1) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:
(i) Ensure that residents #010 and #011 are protected from abuse.
(ii) The plan should include identified staff roles and responsibilities, and a timeline is to be established for the implementation of each component step (i) within the compliance due date.

Please submit the written plan for achieving compliance for inspection #2024-1536-0003 to Rajwinder Sehgal (741673), LTC Homes Inspector, MLTC, by email to torontodistrict.mltc@ontario.ca by June 17, 2024.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to protect residents #010 and #011 from physical abuse.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
i) Resident #011 was discovered lying on the floor close to resident #012's bed. Resident #011 informed both PSW and RPN that resident #012 had pushed them. Resident #012 admitted to pushing resident #011. Both ADON, and RN confirmed that resident #012 pushed resident #011, causing the resident to fall and sustaining an injury.

Failure to protect resident #011 from abuse by resident #012 resulted in harm and injury to resident #011.

Sources: Interviews with the ADON, RN, PSW, record review of the residents #011 and #012's progress notes, assessments, and care plan.
[741521]

Rationale and Summary
ii) A CIS was reported to the Director related to an incident of resident-to-resident physical abuse.

Record review of residents #009 and #010 clinical records indicated resident #009 pushed resident #010 which caused them to fall sustaining injuries. Resident #010 also complained of mild pain to various body parts.

The PSW and RN, both confirmed that the incident was witnessed by staff where resident #009 pushed resident #010.

A PSW, two RNs, and the ADON, all acknowledged that resident #009 physically abused resident #010 causing injury and pain.

The home's failure to protect resident #010 from being abused by resident #009 resulted in an injury to resident #010.

Sources: CIS, resident #009 and #010's clinical records, interviews with PSW, two RNs, and ADON.
[741673]

This order must be complied with by July 12, 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.