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 16, 2023

Inspection Number: 2022-1193-0002

Inspection Type:
Complaint
Critical Incident System
Follow Up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Orchard Villa, Pickering

Lead Inspector	**Inspector Digital Signature**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2023.03.14 14:58:40 -04'00'

Additional Inspector(s)
Amandeep Bhela (746)
Eric Tang (529)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
November 23-25, 28-30, December 1, 2, 5, 6, 8, 9, 12-14, 2022

The following intake(s) were inspected:

- A follow up intake related to plan of care
- Three Critical Incident Report (CIR) intakes related to a fall incident.
- A CIR intake related to improper/incompetent care, medication administration, neglect
- A CIR intake related to an unexpected death.
- A complaint intake related to no back-up generators, menu planning, food production and physiotherapy services
- A complaint intake related to short-staffing, emergency planning
- A complaint intake related to related to power outage, neglect, back-up plan
- A complaint intake related to improper care and dietary concerns
- A complaint intake related to fall incident, plan of care, palliative care
- A complaint intake related to infection prevention and control, availability of supplies, whistle blowing.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order (CO) was found to be in compliance: Order #001 from Inspection #2022_1193_001 related to O. Reg. 246/22, s. 6 (2) was inspected by Carole Ma (741725).

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

Continence Care
Falls Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (5) 3. v.

The licensee failed to inform the Director of the outcome of an investigation for a resident within a set timeframe requested by the Director.

Rationale and Summary

A Critical Incident Report (CIR) for an unexpected death was submitted to the Director for a resident.

A review of the CIR indicated that the report was not amended with the outcome of the investigation.

A Director of Clinical Care (DOC-C) confirmed that the home failed to amend the CIR with the outcome

of the investigation.

There was no risk posed to the resident as a result of the CIR not being amended.

Sources: CIS Report 2693-000038-22 and interview with a DOC-C. [746]

WRITTEN NOTIFICATION: AVAILABILITY OF SUPPLIES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 48

The licensee failed to ensure that linen supplies were readily available at the home to meet the nursing and personal care needs of residents.

Rationale and Summary

A complaint was submitted to the Director indicating that there was a concern around linen being readily available for staff to provide resident care, it was indicated that often times no linen cart was delivered to the resident home areas (RHA), or it was delivered late in the day with not enough linen, at times.

On a specific date, an observation made for a period of time, during which no linen cart was delivered to the unit.

Interviews with staff confirmed that there was a concern at the home with linen supplies. Staff indicated that linen carts were not delivered on time which would impact resident care. They further indicated that they would often have to go looking for linen on other RHAs or in the laundry.

The Environmental Services Manager (ESM) confirmed that linens were delivered late to all RHAs on the date of observation due to a sick call in the laundry department. They further indicated that they are working on staffing to ensure that linen delivery was not impacted when staff called in sick.

Failure to ensure that linen supplies were readily available for staff at the home, posed a risk to the delivery of nursing and resident personal care needs.

Sources: Observation, interviews with staff and ESM. [746]

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)

The licensee has failed to ensure that pain assessments were completed for a resident as specified in the plan.

Rationale and Summary

The home's policy stated that the medication administration record (MAR) was a component of the resident's plan of care.

An order was written in the resident's MAR instructing the registered nursing staff to complete a pain assessment, for a specified period of time. While the order was signed off as complete for the entire duration, there were multiple assessments missing from the resident's medical records.

A Resident Care Manager (RCM) and the Associate Director of Care (ADOC) asserted that the resident's MAR was part of their plan of care and that orders within the MAR were to be provided to the resident. Both staff confirmed that the pain assessments were not completed on multiple shifts as ordered.

Failure to complete the required pain assessments might have hindered staff from monitoring the resident's care needs and impacting their quality of life

Sources: resident's electronic health records, home's policy, staff interviews with an RCM and ADOC. [529]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 29 (3) 15.

The licensee has failed to ensure the plan of care must be based on, at a minimum, an interdisciplinary assessment of the following with respect to two residents' skin condition, including altered skin integrity.

Rationale and Summary

Two residents had experienced a significant change in health and subsequent altered skin integrity that required interventions and treatments.

Upon review, the identified skin conditions for both residents were not included in their respective care plans. Two RCMs, the ADOC, and a DOC-C asserted that a resident's skin conditions, including altered skin integrity, were to be included in their care plan and confirmed the identified skin conditions for both residents were not documented in their care plans.

Failure to include a resident's skin condition in their care plan might have affected the communication between the interprofessional team members and their understanding of the residents' skin conditions.

Sources: residents' electronic health records, staff interviews with RCMs and others. [529]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 4.

The licensee has failed to comply with the pain management policy and procedure for two residents.

In accordance with O. Reg 246/22 s.11 (1) b, the licensee is required to ensure that there is a pain management program that must be complied with.

The licensee did not comply with completing pain assessments for two residents where required.

Rationale and Summary

The home's Pain Management policy and procedure stated that a pain assessment was to be completed when a resident experienced a new pain. Additionally, a pain assessment was also required to be completed every shift for 72 hours when a new pharmacological intervention had been implemented.

A resident experienced a significant change in health and developed a new pain to a specific area. An RCM and the ADOC confirmed that a pain assessment was required at that time, but it was not completed.

A second resident experienced a significant change in health and was prescribed a new pain medication. A DOC-C asserted that a pain assessment for this resident was to be completed every shift by the registered nursing staff for 72 hours, and confirmed the assessments were not completed on multiple shifts during this time.

Failure to complete the required pain assessments for both residents might have hindered staff from monitoring their pain level and health condition.

Sources: residents' electronic health records, pain management policy, staff interviews with an RCM others. [529]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to provide strategies to monitor a resident after their fall. Specifically, staff did not adhere to completing the head injury routine (HIR) as per the home's Falls Management policy.

Rationale and Summary

A resident had an unwitnessed fall.

The home's Falls Management indicated that a HIR was required to be completed by the registered nursing staff at scheduled intervals for 72 hours.

Record review indicated that there were multiple HIRs not completed between this timeframe. An RCM and the Director of Care (DOC) confirmed the same. Both staff asserted that HIR was to be completed registered nursing staff for residents that experienced unwitnessed fall.

Failure to complete the required HIRs might have hindered the registered nursing staff from monitoring the resident's post-fall health condition.

Sources: resident's electronic health records, home's policy on Falls Management, staff interviews with an RCM and DOC. [529]

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) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A resident experienced a fall that led to a significant change in health condition and subsequent altered skin integrity.

An RCM and the DOC stated that a wound care assessment was to be completed by the registered nursing staff when a resident exhibited altered skin integrity. Both staff confirmed that the required assessment was not completed for this resident.

Failure to completing a wound care assessment might have impacted staff from monitoring and managing the resident's skin conditions.

Sources: resident's electronic health records, staff interviews with an RCM and DOC. [529]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure a resident had received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, when they exhibited altered skin integrity.

Rationale and Summary

A resident experienced a significant change in health condition and subsequent altered skin integrity that required interventions and treatments.

As per the resident's health records, a treatment was prescribed on a specific date, but it did not

register in their treatment administration record (TAR).

An RCM and the DOC confirmed the identified wound care order for the resident was not entered and processed. The RCM and the DOC, however, were unable to verify if the identified treatment was not provided to the resident.

Failure to provide the required wound care treatment to the resident might have impacted wound healing and their quality of life.

Sources: resident's health records, staff interviews with an RCM and DOC. [529]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that a resident was assessed by the LTCH's Registered Dietician (RD) when they were exhibiting altered skin integrity.

Rationale and Summary

A resident experienced a significant change in health and subsequent altered skin integrity that required wound care and non-pharmacological intervention.

The home's Skin and Wound Program policy indicated that a referral to the RD was to be made for all residents exhibiting altered skin integrity. An RCM and the DOC asserted that nursing staff were expected to adhere to the identified step.

Record review, the RCM and the DOC confirmed that a RD referral and assessment were not completed for this resident in relation to their impaired skin integrity.

Failure to involve the RD to assess the resident might have impacted their wound care interventions and lengthened healing time.

Sources: resident's health records, home's Skin and Wound Program policy staff interviews with an RCM and DOC. [529]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard, section 9.1 (f) Additional Precautions

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

The IPAC Standard for Long-Term Care Homes, section 9.1 Additional Precautions (f) states the licensee shall ensure that Additional Precautions are followed in the IPAC program. Additional Precautions shall include: f) Additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal.

Rationale and Summary

A PSW was observed entering a room on additional precautions. The PSW had put on the required additional PPE, however, the gown was not tied at the neck and waist, leaving most of their back exposed.

According to the home's policy for donning a gown, the instructions stated to 'cover torso and wrap around back, fasten in back of neck and waist', with a corresponding picture that showed this.

The IPAC lead stated that the PSW did not meet the home's expectation for donning a gown. In failing to adhere to the proper application of PPE, there was a risk of transmission of infectious agents, including COVID-19.

Sources: Observations, interview with IPAC lead, home's Donning and Doffing of Personal Protective Equipment, last revised December 2, 2022. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (7) 11, IPAC Standard, section 10.1

The licensee has failed to ensure that their hand hygiene program included access to hand hygiene agents at the point of care with 70-90% alcohol content.

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

Rationale and Summary

ABHR dispensers in the hallway and resident rooms of two units were found to have an expiry date of August 2022. Both units were on a COVID-19 outbreak at the time. When Inspectors returned to one of the units later in the day, the ESM and housekeeping staff member were observed removing the expired products and replacing them with non-expired ABHR. The ESM acknowledged the ABHR was expired and should not be used. On a specific date, an Inspector found expired ABHR in the Main Dining Room with expiry dates of June 2022 and August 2022. The Nutrition Manager stated they would have the expired ABHR replaced right away.

The IPAC lead confirmed that in using expired ABHR, effective hand hygiene could not be performed, and consequently residents were put at risk for transmission of infectious agents, including COVID-19.

Sources: Observations, interviews with ESM, Nutrition Manager and IPAC lead. [741725]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home was carried out.

Rationale and Summary

1) The home failed to comply with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes regarding COVID-19 asymptomatic screen testing. The directive refers licensees to the requirements set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. This

guidance document states that homes must ensure that staff, caregivers, student placements and volunteers working in or visiting a long-term care home must be tested for COVID-19 using an antigen test at least two to three times a week depending on the individual's COVID-19 vaccination status.

The licensee was conducting COVID-19 rapid antigen tests (RAT) on all visitors and staff entering the home while in a COVID-19 outbreak. On a specific date, Screener #114 was observed conducting a test without recording the start time and reading the result around the three-minute mark. On another date, Screener #111 stated they do not record the start time of the test if they are busy and admitted to reading the result at times 30 minutes after the start.

At first, the IPAC lead stated that the test result could be read within 3-5 minutes of the start time, but after reviewing the manufacturer's instructions online, they stated the home usually waits for 15-20 minutes. The IPAC lead also replied that the screener should be writing down the time and that additional education would be provided.

According to the manufacturer's instructions and the home's RAT administration audit, the test results should be read at 15 minutes and not after 20 minutes; reading results outside of this time frame is incorrect and may give inaccurate results.

By not conducting the COVID-19 RAT according to the manufacturer's instructions and to the standards of the home during an ongoing COVID-19 outbreak, the home placed residents at risk for COVID-19 exposure and infection.

Sources: Observations, interviews with Screener #111, #114 and IPAC lead, RAT manufacturer's instructions, home's Audit Summary Report – Deficiency and Summary details – Panbio Administration Audit Summary Information. [741725]

2) The home failed to comply with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes. For staff wearing masks, the directive refers licensees to the requirements set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. This guidance document states that homes must ensure that all staff comply with masking requirements at all times. Masks must not be removed when staff are interacting with residents or in designated resident areas.

On a specific date, a PSW was observed sitting in a resident lounge without wearing a mask. A resident was seated in the same room watching television. The PSW asserted the lounge had been temporarily changed into a staff break room specifically for staff providing care to COVID-19 positive residents, but a sign indicating this usage was not posted at the time.

The IPAC lead confirmed the resident lounge was temporarily being used to cohort staff during break time. The IPAC Lead also acknowledged that with the PSW not being masked, the resident was a risk of being exposed to COVID-19 transmission and infection.

Sources: Observations, interviews with PSW and IPAC Lead. [741725]

3) The home failed to comply with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes regarding the implementation of a COVID-19 outbreak preparedness plan. This plan must include at a minimum, conducting regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. This guidance document states that homes must conduct weekly IPAC audits when on outbreak that must include at a minimum the COVID-19: Self-Assessment Audit. Homes are also required to follow direction from their local public health unit in the event of an outbreak.

In two CIRs submitted to the Ministry of Long-Term Care (MLTC), the local public health unit declared a COVID-19 and an acute respiratory illness (ARI) outbreak in the home on two separate dates. Upon entering the home, the Inspector requested completed COVID-19 Self-Assessment Audits for review. The home returned three audits, each showing a specific date for when it was conducted. The audit forms were printed and completed by hand ("paper audits").

On a specific date, the IPAC lead stated the home had conducted weekly COVID-19 audits while on outbreak, however, a 10-day gap between the two of the audits was identified. The IPAC lead then made a series of conflicting statements admitting the home had not conducted weekly audits but also maintaining IPAC measures were in place due to daily visual checks on the units.

The day after the interview, the IPAC lead gave the Inspector a series of four audits that were completed from a digital format and three days later, they gave the Inspector a series of four paper audits. Each batch contained audits with matching dates indicating the audits had been done weekly and accounted for the 10-day gap. The IPAC lead stated they were completed by an IPAC associate without their knowledge. These audits were not accepted as being credible due to inconsistent statements provided by the IPAC lead related to how these audits came into being, and digital evidence that contradicted a narrative that was provided.

As per a series of email correspondences from a Senior Public Health Inspector at the Health Protection Health Department for The Regional Municipality of Durham to the IPAC lead, the home was directed to ensure the audits were conducted weekly during the duration of the outbreak, in the affected units. The emails also provide a link to the COVID-19 Self-Assessment Audit tool.

In failing to conduct weekly COVID-19 Self-Assessment Audits during a COVID-19 and ARI outbreak and in demonstrating a lack of accountability for this non-compliance, the home places residents at potential risk for transmission of infectious agents, including COVID-19.

Sources: CIRs, COVID-19 Self-Assessment Audits, interview with IPAC lead, email correspondences between Senior Public Health Inspector at the Health Protection, Health Department with The Regional Municipality of Durham and IPAC lead. [741725]

WRITTEN NOTIFICATION: OBSTRUCTION, ETC.

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 153 (b)

The licensee has failed to ensure that a record or other thing that has been demanded by an inspector is not destroyed or altered.

Rationale and Summary

On a specific date, a concern was raised to the IPAC lead that the home did not conduct weekly COVID-19 Self-Assessment Audits while in a COVID-19 outbreak, as directed by the local public health unit.

The day after this interview, the IPAC lead gave the Inspector a series of four audits that were completed from a digital format. The IPAC lead stated an IPAC associate had completed them on a weekly basis and without their knowledge. Digital evidence was then gathered that refuted this explanation. Three days later, the IPAC lead gave the Inspector a series of four paper audits and stated the IPAC associate had completed them on a weekly basis without their knowledge. The IPAC lead also stated they had transcribed this second batch of paper audits into a digital format, on a date and time that matched the digital evidence that was found.

Upon review of both sets of audits in question, it was noticed that a time was not written into any of the paper audits for when they were allegedly performed, but that a time was entered for each of the digital audits in the series. When asked about this discrepancy and how they handled the time field left blank, the IPAC lead stated twice that they added a time into the transcribed digital audits.

In altering documents related to COVID-19 Self-Assessment Audits while in an outbreak for COVID-19, the licensee placed residents at risk for potential exposure and transmission of infectious agents, including COVID-19.

Sources: COVID-19 Self-Assessment Audits, interviews with IPAC lead, digital photos of IPAC lead's files, folders and document properties for COVID-19 Self-Assessment Audits. [741725]

COMPLIANCE ORDER CO #001 POST-FALL ASSESSMENT TOOL

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

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

1. Complete a two-week audit of all falls on the Aspen Unit to ensure the post-fall assessments are fully completed.
2. Provide on-the-spot education required to the registered nursing staff if issues are identified in the audits.
3. Ensure all audits are documented and educational records are kept on file and made available upon request.

Grounds

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

1) A resident had a witnessed fall without injury. The resident was assessed by a nurse, however, the post-fall assessment tool was not conducted. A DOC-C confirmed that the post-fall assessment tool was not conducted for the resident on that day, and that it should be completed for every fall incident.

The home's "Falls Management" policy and "Post-Fall Clinical Pathway" training material, stated a post-fall assessment tool needs to be completed after every fall.

By not conducting the post-fall assessment tool, potential fall interventions were not identified and implemented. The following day, the resident had another fall that resulted in a significant change in health status.

Sources: Resident medical records, interview with a DOC-C, home's Policy Falls Management, January 2022, and Post-Fall Clinical Pathway, last reviewed January 2022. [741725]

2) A resident had experienced an unwitnessed fall, that led to a significant change in health condition. A review of the home's Falls Management policy indicated that registered nursing staff were to complete a post-fall assessment tool.

Upon reviewing the post-fall assessment tool, the medication section of the tool was left undocumented. An RPN and DOC-C stated that the post-fall assessment tool was to be completed in its entirety, and both had confirmed the identified section of the tool was incomplete.

The incompletion of their post-fall assessment tool posed a risk to the resident and may have hindered the staff from identifying the contributing factors to their falls.

Sources: resident's electronic health records, home's Falls Management policy, staff interviews with an RPN and DOC-C. [529]

This order must be complied with by

February 9, 2023

REVIEW/APPEAL INFORMATION

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made

in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to

review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.