Ontario

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

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

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

Original Public Report

Report Issue Date: November 7, 2024	
Inspection Number: 2024-1202-0001	
Inspection Type: Critical Incident	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Frost Manor, Lindsay	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspector	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1- 4, 2024

The following intake(s) were inspected:
Intake: #00110130 -CI# 2703-000001-24 - Failure of major equipment.
Intake: #00119409 -CI# 2703-000003-24 - Respiratory Outbreak.
Intake: #00126827 -CI# 2703-000009-24 - Respiratory Outbreak.

The following **Inspection Protocols** were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: IPAC Lead hours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee failed to ensure that the infection prevention and control lead worked regularly in that position, on site, for at least 17.5 hours per week.

Rationale and Summary
The home requires IPAC Lead coverage of 17.5 hours per week. However, during the interview, the IPAC Lead/DOC confirmed they only dedicate 2 days a week to the program, which falls short of the required hours.

Failure to ensure the IPAC lead works the required hours at the home puts residents at increased risk of healthcare associated infections.

Sources: Time card, and interviews with the IPAC lead/DOC.

WRITTEN NOTIFICATION: Director of Nursing and Personal Care Hours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 4.
Director of Nursing and Personal Care
s. 250 (1) Every licensee of a long-term care home shall ensure that the home's

Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
The licensee failed to ensure that the Director of Nursing and Personal Care worked regularly in that position, on site, for at least 24 hours per week.

Rationale and Summary
The home is required to have Director of Nursing and Personal Care coverage of 24 hours per week. However, the document review and interview with the IPAC Lead/DOC confirmed that they provide less than 24 hrs coverage as Director of Care which is required in legislation.

Failure to ensure the DOC works the required hours at the home is a risk to not have residents' needs met.

Sources: Interview with IPAC lead/DOC and time card for DOC/IPAC Lead.

COMPLIANCE ORDER CO #001 Compliance with manufacturers' instructions

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

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

1) If the home decides to continue using the Warewashing Procedures poster, as a staff reference, they shall do the following:
   a) incorporate the steps listed on the poster into the refresher training as per condition 2) of Compliance Order #002,
   b) move the poster to a location where it can be easily viewed at eye level,
   c) remove the poster (in the dish room) if it will no longer be used as a reference.

2) The Nutritional Care Manager (NCM) will consult the dishwasher manufacturer to determine the best course of action to rectify the lack of low water level alarm to notify the operator of a malfunction (such as a drain not closing) and take the appropriate corrective actions. Keep a record of the communication between both parties, and the corrective actions taken, and provide to inspectors immediately upon request.

3) The NCM will develop a protocol for checking for debris in the dishwasher machine, including at minimum cleaning out internal drains and strainers as per manufacturer's instructions and add this protocol to the refresher training to all management team and staff who are responsible for overseeing or operating the home's dishwashing machine as per condition 2) of Compliance Order #002.

4) Keep a documented record of the training in conditions 1) a. (if applicable) and 3) including:
   a) date,
   b) content,
   c) NCM name (trainer) and signature,
   d) list of staff and management names who required the training as per condition 3),
   e) signatures to attest they have received and understood the training,
   f) provide this record to Inspectors immediately upon request.

5) After completion of the training, the NCM will check for staff compliance by performing three random audits per week, (covering a breakfast, a lunch and a

dinner each week) for four weeks (12 audits in total), checking to ensure staff are following the training related to conditions 1) a. (if applicable) and 3) of this order.

6) Keep a documented record of all completed audits as per condition 5), including at minimum: the date and time (breakfast/lunch/dinner), whether or not compliance was observed, actions taken for non-compliance if identified, NCM signature (auditor), and make the record immediately available to Inspectors upon request.

Grounds
The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary
At the time of the inspection a Cook/Dietary Aide acknowledged they could hear a water circulation concern with the dishwasher and checked the bottom of the machine, finding a tea bag that was preventing the stopper from completely sealing the drain hole. After the debris was removed and the stopper and screens were replaced the Cook confirmed that the water had returned to the desired level and the last three water temperature readings observed on the gauge rose to above the minimum of 50°C.

The Dishwasher Owner's Manual stated, 'One of the major causes of component failure has to do with pre-scrapping procedures. A dish machine is not a garbage disposal; any large pieces of material that are put into the machine shall remain in the machine until they are either broken up (after spreading out on your ware!) or physically removed. Strainers are installed to help catch debris, but they do no good if they are clogged. Have operators regularly inspect the pan strainers to ensure (1) that they are free of soil and debris and (2) they are in the tub. The instruction manual also directed operators to clean out the machine at the end of every workday.

The dishwasher Warewashing Procedures poster was affixed next to the dish machine, but too high on the wall to read. A picture was taken to enable reading the poster by zooming in the instructions. In the second instruction for set up, the operator was to ensure the machine was clean and nothing was in the drain opening, and that the drain stopper and screens were in place. The job routines for the day shift Dietary Aide or Cook positions did not include any instructions for operating or cleaning the dish machine.
After becoming aware that the dish machine water temperature was below the home's required minimum of 50°C (122°F) during the washing/rinsing cycles of the lunch dishware, the Cook/Dietary Aide acknowledged they could hear the dishwasher was not running the water. They indicated that some water was leaking out and now that the debris (tea bag) was cleared the temperature was back up to about 53°C, explaining that sometimes just the smallest little thing will do that. The Cook acknowledged they could hear there wasn't enough water circulating, the water level should have been up higher, it sounded like a dry run for probably the last four cycles. They confirmed a part was not sealing and closing because the tea bag was stuck.

By failing to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, the licensee placed residents at risk of healthcare-associated infections via contact transmission from improperly cleaned/sanitized dishware.

Sources: dish room observations, Dishwasher Owner's Manual, Warewashing Procedures poster, Dietary Aide and Cook job routines, Cook/Dietary Aide interview.

This order must be complied with by December 30, 2024

COMPLIANCE ORDER CO #002 Food production

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)

Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

1) The Nutritional Care Manager (NCM) will review and revise the home's 'Low Temperature Dishwasher Audit and Chemical Checks' log sheet to ensure it incorporates all components of the homes 'Dish Machine Temperature and Sanitizer Monitoring and Recording' policy, including space for documentation of:

    a) corrective actions (as required)
    b) parts per million (ppm) of the sanitizer check
    c) weekly sign off by the Nutritional Care Manager (NCM)

2) The NCM will develop and provide in-person refresher training to all management team and staff who are responsible for overseeing or operating the home's dishwashing machine, including at a minimum the following content:

    a) standardized testing methods for determining safe water temperature and sanitizer concentrations (for example: gauge and/or waterproof thermometer readings, sanitizer test strips),
    b) when to perform the checks and how to record readings and corrective actions,
    c) what the safe parameters are for water temperature and sanitizer concentration ppm and what to do if readings are outside the acceptable values.

3) Keep a documented record of the training in condition 2) including:

    a) date,

b) content,
c) NCM name (trainer) and signature,
d) list of staff and management names who required the training,
e) signatures to attest they have received and understood the training, and
f) provide this record to Inspectors immediately upon request.

4) After completion of training, check for staff compliance by performing three random audits per week, (covering a breakfast, a lunch and a dinner each week) for four weeks (12 audits in total), checking to ensure staff are following the training that was provided as per condition 2).

5) Keep a documented record of all completed audits as per condition 4), including at minimum: the date and time (breakfast/lunch/dinner), whether or not compliance was observed, actions taken for non-compliance if identified, NCM signature (auditor), and make the record immediately available to Inspectors, upon request.

6) The NCM (or delegated management team member covering in their absence) will review the 'Low Temperature Dishwasher Audit and Chemical Checks' log sheet weekly (or as per the home's current protocol) and sign off that it has been checked including documentation of any corrective actions that were taken by the NCM or their delegate.

7) Repair, clean or replace the opaque glass that obscures the temperature gauge readings for the water flowing into the dishwasher machine.

Grounds
The licensee failed to ensure that the staff of the home complied with policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

Rationale and Summary
The Environmental Services Manager (ESM) and a Cook/Dietary Aide failed to

discontinue use of the dishwashing machine when they became aware that the water temperature readings had fallen below the home's required minimum of 50 Celsius (°C)/122 Fahrenheit (F) during the washing/rinsing cycles of the lunch dishware.

The dish washer water temperature fell below the safe minimum of 50°C (122°F), on eight out of the eleven readings that were taken during the washing and rinsing cycles for the lunch dishware.

During the washing and rinsing of the lunch dishware, the sanitizer test strip colour for the dish washer chemical check matched 25 parts per million (ppm) which was below the acceptable minimum of 100 ppm.

Multiple blanks were observed on the 'Low Temperature Dishwasher Audit and Chemical Checks' log sheets for a lookback period of three months, and the ESM confirmed in an email that one of the staff had missed documenting 21 times.

The home's 'Dish Machine Temperature and Sanitizer Monitoring and Recording' policy, instructed staff on the steps to take if the temperature was not within the acceptable range or the sanitizer concentration was not within acceptable limits.

A review of one of the home's monthly log sheets showed a morning entry noting that the sanitizer was not working and steps were not taken in accordance with the homes 'Dish Machine Temperature and Sanitizer Monitoring and Recording' policy. The log sheet had no specified column or space for staff to document corrective actions and no area for the Nutritional Care Manager (NCM) to sign off weekly that they had reviewed the log sheet as per the home's policy.

An email was provided by the ESM, confirming that the dish machine manufacturer had instructed them that the dish machine was certified to run at 120°F (48.8°C) with the sanitizer reading 100 ppm.

After seeing the lunch time water temperature reading of 40°C, the Cook/Dietary Aide agreed that the temperature should have been a little higher. They were not concerned about the dishes that were just processed, because they had been told in the past by the manufacturer's representative, that as long as the temperature wasn't too far below 50°C (122°F) the sanitizer would do the job.

The ESM confirmed if the dish machine water temperatures were between 50 and 60°C it was okay, but if it dipped below 50°C (122°F) they would have to shut it down and initiate a contingency plan, using paper plates, make calls and they couldn't use the dishwasher until it was fixed, and temperatures were back within the safe range. The ESM confirmed that the water temperature gauge was difficult to read, and when they looked at a zoomed in picture of the gauge, they confirmed that one of the lunch time readings was 40°C (104°F), which was under the lowest safe temperature. When the 'Dish Machine Temperature and Sanitizer Monitoring and Recording' policy was brought to their attention they confirmed being unfamiliar with it, and after a search of the kitchen acknowledged that the home had no waterproof thermometer to complete step #5 of the policy. The ESM did not express any need for action when the water temperature was reading 40°C, as they thought the sanitizer would do the job.

A second Cook/Dietary Aide explained that the sanitizer concentration for the dish washer needed to be a minimum of 100 ppm as per policy, and they confirmed it was too low at 25 ppm when they demonstrated the test strip check, part way through the washing of the lunch dishes. They confirmed using a food thermometer to take the morning temperature because they had a hard time reading the gauge, so they dip the thermometer into the dish machine water after running a cycle and opening the door. They had not yet recorded the lunch readings on the log sheet but confirmed that the readings had been good before starting.

By failing to ensure that the staff of the home complied with policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service, the licensee placed residents at risk of healthcare-associated infections from improperly cleaned and sanitized

dishware.

Sources: Dish room observations, 'Dish Machine Temperature and Sanitizer Monitoring and Recording' log sheets and policy, staff interviews (two Cook/Dietary Aides and the ESM).

This order must be complied with by December 30, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall ensure the following:

1) The IPAC Lead and DOC will ensure all nursing staff, including agency staff, new hires, and students, are trained in hand hygiene based on the Four Moments of Hand Hygiene.

2) The IPAC Lead will create a “Train the Trainer” program for Hand Hygiene Auditors, following best practices. They will conduct initial audits of clinical and housekeeping staff to identify gaps and discuss results with the administrator.

3) After identifying gaps, the IPAC Lead will provide in person training on hand hygiene methods (soap and water, alcohol-based) for all nursing staff.

4) The Environmental Services Manager (ESM) and Administrator will establish a process to clean high-touch surfaces at least twice daily during outbreaks. They with IPAC Lead, will also train environmental services staff on these cleaning procedures.

5) The IPAC Lead or ESM will train frontline staff on how to properly clean and disinfect shared equipment, including guidelines on contact time and frequency.

6) The IPAC Lead, DOC, and Administrator will ensure residents are reminded to practice hand hygiene before meals and snacks. They will update the hand hygiene policy and create a daily auditing process to monitor compliance.

7) The IPAC Lead or designate will educate all staff on the proper use of PPE, including selection, application, removal, and storage. They will conduct at least two daily audits of PPE practices for four weeks.

8) All training and audit records will include staff names, training dates, demonstration outcomes, and feedback. These records must be available to inspectors upon request.

Grounds

1. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.
Specifically, the licensee failed to ensure that evidence-based practices related to potential contact transmission and required precautions were followed as it is required by Additional Precautions 9.1 (b) under the IPAC Standard for Long Term Care Homes, dated September 2023.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1(b). Specifically, the licensee shall ensure Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic

procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
Due to the COVID-19 outbreak, meals were delivered to residents' rooms instead of communal dining. During lunchtime, staff were observed delivering meals. One staff member demonstrated inconsistent adherence to hand hygiene (HH), entering and exiting rooms without performing HH.

After donning PPE, another staff member entered a room with a meal, assisted a resident to the washroom, and then returned to the resident's bed space without changing gloves or performing HH throughout the care sequence.
During the observation in another area, a staff member was observed exiting the bedroom of a resident on droplet/contact precautions. This staff member used alcohol-based hand rub to clean their gloves upon exit.

Failure to perform hand hygiene and remove before removing gloves in accordance with best practices paces residents at increased risk of infections.

Sources: Observations, Interview with IPAC Lead/DOC, policy review.

2. The licensee has failed to ensure the implementation of any standard, or protocol issued by the Director with respect to infection prevention and control.
Section 9.1 (g) under Additional precautions of the IPAC Standard for Long-Term Care Homes (Revised September 2023), states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program at minimum, Additional Precautions shall include modified or enhanced environmental cleaning procedures.

Rationale and Summary
During an inspection, it was found that the home did not provide enhanced cleaning during outbreaks or for residents on additional precautions. The COVID-19 Outbreak

policy required enhanced cleaning for frequently touched surfaces and prompt disinfection of contact surfaces near positive cases.

However, there was no process for housekeeping to complete or document enhanced cleaning. Interviews with the IPAC Lead, Environmental Services Manager, and housekeeping staff revealed a lack of understanding of enhanced cleaning and no education or training on infection prevention and control policies.

Failing to complete the cleaning and disinfection as required puts the home at risk for increased disease transmission.

Sources: Daily high touch surfaces logs, Homes Policy, and interview with the staff.

3. The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with, specifically, the licensee has failed to provide hand hygiene to all residents prior to and after eating. In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2022, section 10.2 (c). The licensee shall also ensure that the hand hygiene program for residents has a resident centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

Rationale and Summary
During lunchtime, while meals were delivered to residents' rooms, a staff member was observed delivering food without offering assistance with hand hygiene (HH) to a resident. Another staff member also delivered a meal to a different resident; although hand hygiene was performed, assistance was not offered they did not offer or assist the resident with HH.

The IPAC Lead confirmed that all residents should be offered hand hygiene before meals and snacks if they are able to follow instructions. Residents requiring assistance should receive help with hand hygiene.

Failure to staff not providing residents with hand hygiene before meals puts residents at risk for infection.

Sources: Observations, interview with IPAC lead.

4. The licensee failed to ensure the staff is wearing and using PPE in accordance with best practices and manufacturers' instructions.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 f). The licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements: Specifically the licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program including appropriate selection application, removal and disposal.

Rationale and Summary
During lunch in the dining room, a staff member was observed wearing an N95 respirator with the straps crisscrossed at the crown of the head, compromising the fit and contradicting 3M's guidelines, which specify that the lower strap should be flat at the nape of the neck and the upper strap on the crown for a secure fit.

The Inspector noted that goggles were stored along the rails and hanging from hooks on the walls. Observations included staff cleaning goggles and then placing wet goggles on their faces before entering residents' rooms. In another instance, a staff member placed used goggles on a handrail after doffing them. Additional observations showed staff cleaning goggles and leaving them on handrails.

The IPAC Lead could not provide information on the proper cleaning process for goggles or the correct procedures for storing used goggles to prevent cross-

contamination. During an interview, the IPAC Lead acknowledged that goggles should not be placed on handrails.
Failure to properly use and handle PPE places the residents at increased risk of healthcare associated infections.

Sources: Observations, interviews with staff.

This order must be complied with by December 30, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 6.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
6. Convening the Outbreak Management Team at the outset of an outbreak and regularly throughout an outbreak.

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

Specifically, the licensee shall ensure the following,

1) The IPAC Lead will identify key stakeholders for the Interdisciplinary IPAC Outbreak Management Team (OMT) and maintain a list with names, roles, and contact information.

2) The IPAC Lead will set a schedule for OMT meetings and a communication plan to implement and review infection control practices as directed by Public Health Authorities during outbreaks.

3) The IPAC Lead will ensure the OMT conducts a post-outbreak debrief and gap analysis to evaluate intervention effectiveness The review will encompass the following areas:
   a) Assess the effectiveness of outbreak detection and review application of appropriate case/outbreak definitions.
   b) Evaluate the promptness in placing residents on additional precautions.
   c) Review audit results for hand hygiene, PPE, and housekeeping practices, and check the status of social activities.
   d) Review the effectiveness of communication from frontline staff to the IPAC OMT and from the IPAC OMT to stakeholders, including notifications, memos, and signage distribution.
   e) Assess staffing levels and availability of essential staff, including after-hours access to Infection Control Practitioners (ICP), and review staffing practices.

4) A written record of all meetings, including date, time, and attendees, and minutes detailing reviewed outbreaks and actions taken, must be maintained and made available to inspectors upon request.

Grounds
The licensee has failed to ensure to convene an Outbreak Management Team (OMT) at the outset of an outbreak and continue throughout the outbreak and to conduct a debrief session with the OMT in accordance with O. Reg 262 102 (7) 6 and IPAC standard for Long-Term Care Homes (LTCHs), revised September 2023.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director concerning a respiratory outbreak at the Long-Term Care (LTC) Home, which occurred from June 21, 2024, to July 21, 2024.

The LTC Home could not provide documentation of any Outbreak Management Team (OMT) meetings during or after the outbreak. Consequently, there were no findings or recommendations for improving outbreak management practices..

The IPAC Lead was unaware of the requirement for the OMT was unaware of the requirement for the OMT to meet and review the outbreak status, as well as the need for a post-outbreak debrief session. This lack of awareness increased the risk of infectious disease exposure for residents and staff.

Failure to include relevant stakeholders, members of OMT through all stages of the outbreak places residents at increased risk of acquiring healthcare associated infections.

Sources: LTCH's Outbreak Documentation; line list, Public Health Report, Outbreak management policy, interview with IPAC Lead/DOC.

This order must be complied with by December 30, 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
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.