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: July 19, 2024

Inspection Number: 2024-1337-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Kensington Health Centre

Long Term Care Home and City: The Kensington Gardens, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4-7, 10-14, 17, 20-21, and 24-25, 2024

The following intake(s) were inspected:

- Intake: #00109818/Critical Incident (CI) #2852-000023-24 – related to resident-to-resident physical abuse
- Intake: #00109900/CI #2852-000024-24; Intake: #00112864/CI #2852-000052-24 – were related to staff to resident physical abuse
- Intake: #00112408/CI #2852-000042-24; Intake: #00113247/CI #2852-000055-24; Intake: #00114470/CI #2852-000059-24 – were related to emotional abuse towards a resident
- Intake: #00111271/CI #2852-000036-24 – related to improper care
- Intake: #00117210/CI #2852-000072-24 and Intake: #00114321/CI #2852-000058-24 – were related to disease outbreaks
- Intake: #00111030/CI #2852-000028-24/CI #2852-000029-24 – related to alleged resident neglect
- Intake: #00116198 and Intake: #00117314 – complaints related to alleged resident neglect

- Intake: #00112873 – complaint related to bed refusal

The following intake(s) were completed:
Intake: #00112537/CI #2852-000048-24; Intake: #00112751/CI #2852-000050-24; Intake: #00112850/CI #2852-000051-24; Intake: #00116607/CI #2852-000071-24; Intake: #00118007/CI #2852-000075-24 and Intake: #00118228/CI #2852-000080-24- were all related to disease outbreaks

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (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 the residents as specified.

Rationale and Summary

1) A resident's plan of care indicated an intervention related to their behaviour.

Staff reported that when a resident was exhibiting a responsive behaviour an intervention was not in place causing a co-resident to become injured.

A co-resident was injured when the home failed to provide an intervention to a resident exhibiting an identified responsive behaviour.

Sources: Two residents clinical records and staff interviews.

2) A resident's plan of care specified two staff assistance for care.

The home confirmed that the staff provided care alone to a resident.

Failure to follow a resident's plan of care related to staff assistance increased their risk of harm.

Sources: A resident's clinical records, home's investigation notes and staff interviews.

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that when any alleged incidents of abuse and neglect involving residents were reported, the staff failed to conduct a head-to-toe physical assessment of the resident and document findings in their health records, as required by their policy.

Rationale and Summary

1) The home submitted a CI report regarding an alleged resident neglect.

There was no documentation that a physical assessment was completed for the resident.

Staff stated there was no physical assessment completed for the resident after the alleged resident neglect was reported.

2) The home submitted a CI report related to an alleged resident abuse from a family member.

There was no physical assessment completed for the resident related to the alleged abuse.

Staff stated they did not complete a physical assessment after they received a report that the resident was allegedly abused by their family member.

3) The home submitted a CI regarding an alleged staff to resident abuse.

There was no physical assessment completed for the resident.

Staff stated they did not complete a physical assessment after they were made aware of the alleged staff to resident abuse and neglect.

The home stated that staff were expected to complete a physical assessment or skin assessment for any alleged resident abuse or neglect.

Failure of the home to conduct physical assessments of the residents after an alleged abuse or neglect could result in delayed implementation of strategies to assist them.

Sources: M1-010 Prevention and Investigation of Abuse and Neglect Policy (December 2023), three residents clinical records and staff interviews.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #003 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 immediately report to the Director when an alleged incident of abuse of four residents resulted in harm or risk of harm to the residents.

Rationale and Summary

1) An alleged resident abuse was reported by the staff to the home.

The incident was reported to the Director two days after.

The home confirmed that the CI was submitted to the Director two days late.

Sources: M1-010 Prevention and Investigation of Abuse and Neglect Policy (December 2023), CI #2852-000059-24 and staff interviews.

2) A resident reported an alleged physical abuse from a staff during care.

The home submitted a CI report five days after.

3) Another resident reported an alleged physical abuse from a staff during care.

The home submitted a CI report three days after.

4) A family member reported an alleged abuse when a resident's religious preference was not maintained by the staff.

The home filed a CI report three days after.

The home stated that they did not immediately report these incidents to the Director.

When the home failed to report alleged abuse of residents immediately, the Director's ability to respond promptly was hindered.

Sources: CI reports #2852-000024-24; #2852-000052-24; #2852-000042-24; and staff interviews.

WRITTEN NOTIFICATION: LICENSEE CONSIDERATION AND APPROVAL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (a)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator 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,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

The licensee has failed to demonstrate circumstances exist which were provided for in the regulations as being grounds for withholding approval.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint regarding the withholding of admission for an applicant. The home cited that they withheld approval due to the absence of physical facilities and staffing resources.

A completed assessment indicated the applicant's independence, adherence to specific policies and fall risks.

The home indicated that concerns about fall risks influenced their decision to withhold admission without requesting further assessments. The home acknowledged that while there was no designated facility in the home for specific recreation, residents were allowed to conduct their specific recreation at a safe distance from the building, as per the home's policy.

The home acknowledged that there were no valid grounds to justify withholding the applicant's admission based on the lack of physical facilities.

The decision had a negative impact on the applicant, as it prevented them from transitioning to their preferred Long-Term Care Home (LTCH), potentially compromising their access to necessary care and support.

Sources: An applicant's application package, Letter from the home regarding withholding approval of admission and staff interviews.

WRITTEN NOTIFICATION: WRITTEN NOTICE IF LICENSEE WITHHOLDS APPROVAL

NC #005 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

The MLTC received a complaint regarding the withholding of admission for an applicant.

The written refusal letter failed to include contact information of the Director.

The home acknowledged that the contact information was not included in the letter.

Sources: Letter from the home regarding withholding approval of admission and staff interview.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 22.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences.

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment with respect to their religious preferences.

Rationale and Summary

A CI report was submitted related to an alleged abuse of a resident.

A resident's religious preference was not maintained by staff.

The home acknowledged that an interdisciplinary assessment regarding the resident's religious preferences were not completed, nor was a plan of care established based on these preferences.

Failure of the home to include a resident's religious preferences in their plan of care resulted in their compromised spiritual and religious needs.

Sources: CI report #2852-000042-24, a resident's clinical records and staff interviews.

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) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident's area of altered skin integrity was

reassessed at least weekly.

Rationale and Summary

A resident's written plan of care indicated that they had an area of altered skin integrity.

Staff stated that for residents with altered skin integrity, a weekly skin assessment was required.

The home stated that several weekly skin assessments for a resident were missed.

There was a risk for delayed implementation of interventions to promote wound healing for a resident when their weekly skin assessments were not completed.

Sources: A resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible;

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Rationale and Summary

A CI report was submitted related to resident to resident physical abuse causing injury.

A resident's plan of care identified behaviours towards other residents, however, no specific strategies were developed.

Staff reported that when the resident was approached by a co-resident, the resident exhibited behaviours causing the co-resident to sustain injuries.

The home acknowledged that had strategies been established, the incident could had been prevented.

When the home failed to establish strategies for managing a resident's behavior there was an increased risk of altercations between residents.

Sources: CI report #2852-000023-24, a resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions

are documented.

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours actions were taken to respond to the needs of the resident including assessments, reassessments and interventions and the resident's responses to interventions were documented.

Rationale and Summary

A resident was transferred to the hospital due to their escalated behaviours and returned to the home with a specified diagnosis.

The home's policy indicated that for a resident with new/escalated behaviours the staff will initiate a specified assessment system to track new or escalated behaviour patterns.

The resident's clinical records indicated they had new behaviours on a specified date. The resident's behaviours worsened over time.

Staff stated that for new/escalated behaviours, staff were expected to initiate a specified assessment. There was no documentation that the specified assessment was completed for the resident for a period of three months.

When the home failed to assess a resident's behaviours, there was a delay in implementing interventions increasing the risk of behaviours.

Sources: A resident's clinical records, M2-965 Responsive Behaviours Policy (August 2017) and staff interviews.

WRITTEN NOTIFICATION: MENU PLANNING

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)

Menu planning

s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,

(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner;

The licensee has failed to ensure that a resident was offered a between meal-beverage in the morning.

Rationale and Summary

A resident's written plan of care indicated they were at high nutritional risk.

Inspectors did not observe the identified in between meal beverage for a resident offered during the morning nourishment pass.

The home stated that a resident was provided a special in between meal beverage to ensure adequate nutrition.

There was an increased nutrition risk to a resident when staff did not offer their morning in between meal beverage.

Sources: Observations in the home, a resident's clinical records and staff interviews.

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 (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 that Additional Precautions were followed in the Infection Prevention and Control (IPAC) program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Section 9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including but not limited to, 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).

Specifically, the licensee did not ensure that staff completed Hand Hygiene (HH) when providing assistance in between residents in a specified dining room.
Rationale and Summary

1) At the time of inspection, the home was on confirmed outbreak.

A staff was observed assisting three different residents from two different tables during meal service. The staff did not perform HH in between contact with these residents. Another staff was observed assessing three different residents from three different tables during meal service but did not perform HH in between contact with these residents.

Both staff stated they failed to perform HH in between resident contact.

The home stated that staff were expected to perform HH when coming into contact between residents during meals.

When staff failed to perform HH in between residents, there was a risk of infection transmission.

Sources: Lunch Meal Service observations in a specified Dining Room, M6-100 Hand Hygiene Policy (March 2020) and staff interviews.

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 are performed regularly (at least quarterly).

Rationale and Summary

2) Review of the IPAC Personal Protective Equipment (PPE) Audits from a specified period revealed audits involved only nursing staff. An electronic file of The Kensington Garden (TKG) HH observations from specified dates revealed only two staff from two different non-nursing departments were audited.

The home stated they currently had no process in place to ensure quarterly audits of all staff were completed.

Failure of the home to conduct regular quarterly audits to ensure all staff can perform IPAC practices specific to their role increased the risk of infection transmission.

Sources: Home's PPE and HH Audits and staff interview.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

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

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

1) Public Health (PH) declared the home in a confirmed respiratory outbreak. The home submitted the CI report to the Director one day after.

2) PH declared the home again in a confirmed respiratory outbreak. The home submitted the CI report to the Director two days later.

The home stated that any confirmed disease outbreak of PH importance was expected to be reported immediately to the Director or to call the Ministry after-hours.

Sources: CI reports #2852-000058-24, #2852-000072-24 and staff interview.

WRITTEN NOTIFICATION: Medication Management System

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the medication system policies and procedures specifically for medication reconciliation.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure accurate administration of medications and must be complied with.

Specifically, staff did not comply with the policy "Medication Administration-General Guidelines, M2-760," dated September 2017, which was included in the licensee's Medication Management Program.

Rationale and Summary

A resident was readmitted to the home from the hospital with a specified diagnosis.

The resident's clinical records showed that a fax message was sent from the hospital to the home with their discharge summary including medication changes pertaining to a specified treatment.

The resident's clinical records revealed there was no medication reconciliation consolidation form completed on a specified date and the physician and pharmacy did not participate in the medication reconciliation. The medication changes were transcribed and processed five days after.

The home acknowledged that the new orders from the hospital were missed. The home also acknowledged that the physician and pharmacist were not informed of the new orders from the hospital and that the medication reconciliation process was not followed as per the home's policy.

When the home failed to perform the medication reconciliation with the interdisciplinary team, it increased the risk of a resident to experience poor health outcomes.

Sources: A resident's clinical records, M2-760 Medication Administration-General Guidelines Policy (Revised September 2017) and staff interviews.

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. 155 (1) (b)]:
The licensee shall prepare, submit and implement a plan to ensure that a specified resident in the home requiring care of their prosthetic device, assistance for meals and triggers for weight variances was not neglected by the licensee or staff. The plan must include but is not limited to:

1) Review of the roles and responsibilities of PCAs, registered staff and RD in a specified unit related to residents with weight variances;
2) Review a specified resident's plan of care related to care of their oral prosthetics, meal assistance and weight monitoring with all PCAs and all Registered staff in specified unit where the specified resident resides;
3) Maintain a documented record of step one and two, including the date, staff attendance and the individuals involved;
4) Develop an audit tool to monitor and document staff compliance related to implementation of a specified resident's plan of care related to care of their oral prosthetics, feeding and nutrition;
5) Audits must be completed for a minimum of four weeks or until 100% compliance is reached;
6) Maintain a document record of audits completed to include but not limited to staff completing the audit, date of audit and any actions taken in response to the audit findings.
Please submit the written plan for achieving compliance for inspection #2024-1337-0004 by email to torontodistrict.mltc@ontario.ca by August 2, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure a resident was not neglected related to care of their oral prosthetics, feeding assistance and weight loss.

Section 7 of the Ontario Regulation 246/22 defines neglect as "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

A complaint was received by the home related to a resident's care of their oral prosthetics, staff assistance and nutrition.

On a specified date, a resident was sent for an appointment. The resident's oral prosthetics were broken and was not properly cared for as indicated on the letter from their appointment.

Staff stated they did not provide care to the resident's oral prosthetics until after a specified date. Registered staff stated that the oral prosthetics were identified in the resident's initial plan of care. Another staff stated that the care of resident's oral prosthetics was not properly provided to the resident for a specified period.

The home verified neglect of the resident's oral prosthetics.

A resident's current written plan of care indicated they were on high nutrition risk with specified intervention in their written plan of care.

A resident's assessments indicated that they required a specified staff assistance for meals. At the time of inspection, the resident was observed not being provided the staff assistance and additional time to complete their meals as indicated in their written plan of care.

The home's documentation from a specified period and staff interviews confirmed that staff were not providing the required assistance for the resident during meals.

A resident's clinical records indicated that they were on weight warnings and lost weight since admission. There were no RD referrals related to weight loss for a period of four months. Staff stated the RD referrals for the resident were missed.

Staff stated the resident lost weight prior to hospital transfer. RD recommended an intervention to monitor the resident's weight. The intervention was not completed for the resident. The home stated that the lack of care related to their oral prosthetics could have contributed to their weight loss.

When the home failed to provide oral prosthetic care, staff assistance as specified in the plan, proper and timely assessments and or reassessments of a resident related to their weights, their health and well-being was jeopardized.

Sources: A resident's clinical records, meal observations, M2-1140 Weight Monitoring Policy (August 2014), home's investigation notes and staff interviews.

This order must be complied with by September 16, 2024

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

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.