Ontario

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

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

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

Original Public Report

Report Issue Date: April 4, 2024	
Inspection Number: 2024-1391-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Langstaff Square Community, Richmond Hill	
Lead Inspector Ana Best (741722)	**Inspector Digital Signature**
Additional Inspector(s) Najat Mahmoud (741773)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-8,11-13, 2024.

The following intake(s) were inspected:

- Intake: #00109843 - related to a Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 9.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

9. Every resident has the right to meet privately with their spouse or another person in a room that assures privacy.

The licensee failed to ensure the residents had an available room that assures privacy.

Rationale and Summary

During a tour of the Long Term Care Home (LTCH), it was observed that in all the home units, the activity room areas were converted into staff breakrooms. It was also observed that in the television (TV) lounge, several residents were watching TV on a regular basis.

Inspector was informed by Personal Support Worker (PSW) #118, the process in the home when a resident wanted to meet privately with their loved one, was to use the activity room identified as the breakroom area, the residents' rooms (several identified as double occupancy rooms), or TV lounge, which as per the staff, was a problem at times as there were residents watching TV, and others in the surroundings.

Resident programs staff #119 indicated they were using the TV rooms as activity program spaces. The Director of Resident programs confirmed there was not a private space designated for residents to meet privately with their loved ones.

Failure to ensure the residents of the home had a private space may lead to emotional distress and limited opportunities to communicate with privacy and dignity.

Sources: Observations, and interviews with staff. [741722]

WRITTEN NOTIFICATION: Residents' Council assistant

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 64 (1)
Residents' Council assistant
s. 64 (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council.

The licensee failed to appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), information related to Residents' council was reviewed.

On the Residents' Council minutes from the last quarter in 2023, it was noted the Council's request to the LTCH's to appoint an assistant for its council.

The President of Residents' Council indicated that previously, the LTCH had appointed the Director of Resident Programs as the assistant, which the council did not accept as they were part of the management team.

The Director of Resident Programs and the Executive Director (ED) confirmed the refusal from Residents' Council. Subsequently, the ED indicated that previously, a staff from the resident programs team who was selected by the Council, could not assist with the role because it exceeded the time of their regular assigned duties. Lastly, the ED confirmed that since, the home has not attempted to follow up with Residents' Council to appoint an assistant.

Failure to appoint an assistant for Residents' Council, may lead to lack of representation, communication and decreased resident advocacy for the residents of the home.

Sources: Minutes from Resident Council, interviews with President of Resident Council, and staff. [741722]

WRITTEN NOTIFICATION: Powers of Family Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)

Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee failed to respond to concerns submitted by Family Council within 10 days of receiving the advice.

Rationale and Summary

During a PCI, Inspector #741722 was informed that answers to submitted concerns to the home, were not responded to within the 10 days.

Several forms were submitted to the LTCH at the beginning of 2024, including a concern related to the activity room usage for residents that was not addressed by the home within the 10 days of receipt. Other submissions made during the same period were not responded.

The President of Family Council indicated the communication process with the home and the submission of concerns represented a challenge as answers were not provided within the indicated time.

The ED acknowledged that an answer to the submitted concern related to activity room usage for resident was missed.

Failing to address concerns from the family council may lead to diminished trust, and lack of advocacy for the residents of the LTCH.

Sources: Langstaff Square Family Council concern and recommendation forms, and

interviews with President of Langstaff Square Family Council, and ED. [741722]

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 (4) (a)
Plan of care
s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition.

The licensee failed to complete a nutritional assessment for resident #001 when there was a significant change in their health condition.

Rationale and Summary

Clinical records for resident #001 were reviewed and indicated that on an identified date, resident #001 experienced a significant change in condition. The physician was informed, and the resident was sent to the hospital for further evaluation. The resident returned to the LTCH with a change in their diet texture. According to the LTCH's policy titled Referral to Dietitian and/or Director of Dietary Services, the nurse will assess all residents for nutritional risk factors and complete a dietary referral, if necessary, in cases such as changes in health status, and return from hospital. Clinical records did not indicate that a dietary referral was made by the registered staff for the resident to be assessed by the Registered Dietitian (RD).

Associate Director of Care (ADOC) #133 and the RD indicated that the expectation of the nurses was to complete a dietary referral upon return from the hospital, and when there was a significant change in the resident's health status. The RD further

indicated that the resident was not assessed upon their return from the hospital.

Failure to complete a dietary referral resulted in no assessment of resident #001's nutritional needs.

Sources: The LTCH's policy titled Referral to Dietitian and/or Director of Dietary Services, clinical records for resident #001, interviews with staff. [741773]

WRITTEN NOTIFICATION: Menu planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the planned menu items were offered and available at lunch time.

Rationale and Summary

During a meal observation, the posted menu for lunch indicated spinach mandarin salad and mango for dessert. During lunch service, the salad was missing mandarin, and the residents were served spinach and onions. The mango on the posted menu was substituted with honeydew for dessert.

The Dietary Aides and Cook indicated that the planned menu should match what is served to the residents and any alterations must be made to the posted menu. The Food Service Supervisor (FSS) confirmed this and indicated that they were responsible to ensure that the changes were made to the posted menu. The RD

indicated that the alterations in the menu resulted in a poor dining experience and palatability for the residents.

Failure to offer residents the planned menu items reduced the dining experience and palatability of the meals for the residents.

Sources: Observation, posted menu, interviews with the FSS, RD and staff. [741773]

WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (8)
Menu planning
s. 77 (8) The licensee shall ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that an alternative meal was made available to resident #001 at breakfast.

Rationale and Summary

During a breakfast observation, resident #001 was provided with a specific food ingredient. Resident #001 indicated they could not eat the specific food ingredient and that this was communicated to the staff. A letter written by the Substitute Decision Maker (SDM), indicated to provide the resident with another specific food ingredient if they refused their meal. Resident #001's care plan indicated to provide the requested food ingredient as an alternative meal.

Progress notes indicated that the resident refused the food ingredient served during breakfast and did not indicate that the requested food ingredient by the SDM was provided to the resident. PSW #126 indicated that the resident had difficulties and did not eat their breakfast.

Failure to ensure that an alternative meal was available to the resident posed a risk to their nutritional intake.

Sources: Meal observation, SDM's letter, resident #001's clinical record, and interview with PSW #126. [741773]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee failed to follow a process to ensure that staff assisting residents are aware of the resident's diets, special needs and preferences.

Rationale and Summary

During a lunchtime meal service, resident #001 was provided a food item. The resident's plan of care indicated that they required a specific diet texture.

Clinical records were reviewed and indicated that the resident was assessed by

Speech Language Pathologist (SLP), and was recommended a specific diet texture due to identified risks for the resident. The resident was reassessed by SLP the following month upon the Substitute Decision Maker's (SDM) request and their diet texture was changed to another texture.

PSW #126, ADOC #133, and the RD indicated that when there were changes to a resident's diet texture a diet order form was completed on Point Click Care (PCC) and the resident's care plan and diet order on PCC were updated. The RD confirmed that the resident's care plan and diet order during the lunch service observation, were not updated as per the LTCH's process.

Failure to follow the home's process to ensure that staff assisting residents were aware of residents' dietary needs posed a risk to the well-being of the resident.

Sources: Meal observation, resident #001's clinical record, interviews with staff. [741773]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that the interdisciplinary team which must include the

Medical Director, the Administrator, the Director of Care (DOC) and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary

The LTCH's medication management system was reviewed during this PCI.

Inspector #741773 identified that there were no quarterly evaluations of the medication management system.

The DOC indicated that the home did not have formal quarterly evaluations of the medication management system which included the Administrator and the Medical Director. The DOC further indicated that only medication incidences were reviewed with the home's Consultant Pharmacist. During the inspection, non compliances related to safe storage of drugs, and medication administration were identified.

Failure to have quarterly evaluations resulted in no evaluation of the effectiveness of the medication management system.

Sources: The LTCH's multi incident review meeting, interview with the DOC. [741773]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

Rationale and Summary

During the inspection, Nursing student #131 was observed leaving the medication cart unlocked and unsupervised at the nursing station when they went to administer medications. Resident #014 was seated across the nursing station desk.

Nursing student #131 confirmed that the medication cart was left unlocked and unattended posing a risk to the residents. Registered Practical Nurse (RPN) #132 indicated that only the nursing students and the registered staff have access to the medication cart. RPN #132, Nursing student #131, and the DOC indicated that the medication cart should remain locked at all times when it is unsupervised.

Failure to keep the medication cart locked when unsupervised posed a moderate risk to the safety and well being of residents.

Sources: Observation, Resident's Medication Administration Record (MAR), Orientation package, interviews with RPN #132, Nursing student #131 and DOC.
[741773]

WRITTEN NOTIFICATION: Construction, renovation, etc.,of homes

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee failed to submit a request for approval to the Director, when proceeding with alterations in the home related the resident home space areas, specifically breakrooms in the different Resident Home Areas (RHAs).

Rationale and Summary

During a tour of the LTCH, it was observed that the activity rooms in each home unit were converted into staff breakrooms.

As per the Long-Term Care design manual 2015, “the program and activity areas must be able to accommodate a variety of resident-focused activities and support social functions which promote resident quality of life”.

The floor plan documentation for each unit, identified the designated breakrooms spaces as activity rooms and not as breakrooms.

Resident council minutes from the last quarter of 2023 indicated residents had requested that the activity rooms were returned to be used as such, as they were used before the COVID-19 Pandemic.

In addition, a concern form submitted by Langstaff Square Family Council at the beginning of 2024, indicated there was no other space identified on the units for residents to go other than the TV room, and dining room, leaving the residents without a permanent space for arts, crafts, puzzles, and games to enjoy with other residents, family, staff or in their own. In addendum, it was documented that in early

2023 during a Town Hall, there was a consideration to reallocate these rooms, but no further action was taken.

The ED informed the alterations to the respective five RHAs identified as activity rooms were transformed since the COVID-19 pandemic was declared, and once it was declared over, no plan was submitted to the Director to reflect the current use of resident home space. The manager as well informed that prior to these RHAs' changes, the staff were utilizing the designated staff breakroom in the basement level.

Failure to submit plans for alterations related to resident home areas may lead to detrimental effects on residents' safety, accessibility, and quality of life.

Sources: Observations in the home units, floor plan documentation, Resident and Family Council minutes, Long-Term Care Home design Manual 2015, and interview with the ED. [741722]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (4) (b)
Administration of drugs
s. 140 (4) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 123 (2);

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

The licensee shall:

1) Develop and implement an orientation package for registered staff and nursing students to include the written policies and protocols for the medication management system as per legislative requirements.

2) A member of the nursing management team or delegated registered staff shall provide re-training to all registered staff and nursing students on the newly developed orientation package for the medication management system. Keep a documented record of training attendance, including dates of training, the individuals who provided the training, the individuals who attended the training including their professional designation, and contents of the education provided.

3) All records will be retained and made available to Inspectors immediately upon request.

Grounds

The licensee failed to ensure that the nursing students were trained on the written policies and protocols for the medication management system as referred to in subsection 123 (2).

Rationale and Summary

During the inspection, Nursing student #131 was observed leaving the medication cart unlocked at the nursing station when they administered medications to resident

#013 unsupervised in the dining room. Resident #014 was seated across the nursing station desk.

Nursing student #131 acknowledged that the medication cart should have been locked and was uncertain if they required supervision by the RPN when they administered medications. Nursing student #131 further indicated that they attended general orientation and were uncertain if the home's written policies and protocols for the medication management system were included. RPN #132 indicated that the nursing students receive their training during general orientation.

The home's general orientation package provided to the students and the attendance sheets were reviewed and did not include training on the home's written policies and protocols on the medication management system.

The DOC indicated that nursing students receive their training from their college and that the home did not provide training on its policies and protocols for the medication management system.

Failure to provide training on the homes policies and protocols on the home's medication management system posed a risk to the residents.

Sources: Observation, Orientation package, interviews with DOC, RPN #132, and Nursing student #131. [741773]

This order must be complied with by May 22, 2024

COMPLIANCE ORDER CO #002 Administration of drugs

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (4) (d)

Administration of drugs
s. 140 (4) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(d) the nursing student administers the drugs under the supervision of the member of the registered nursing staff. O. Reg. 66/23, s. 28 (1).

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

The licensee shall:

1) Conduct a Medication Administration Audit that includes;
a) The supervision of nursing students by the registered staff when medications are administered.
b) Safe practices with medication administration including the locking of the medication carts.

2) The Medication Administration Audits shall be conducted by the DOC or nurse manager designate, twice a week on day shifts, for a period of four weeks. The audits should include shifts where nursing students are scheduled. The audit will include the name of the person completing the audit, the unit, and the name of the registered staff and nursing student administering medications. When concerns arise with medication administration, the audit will indicate what on the spot education was provided.

3) The DOC or nurse manager designate will provide re-training to all registered staff and nursing students on safe medication administration practices. Keep a documented record of training attendance, including dates of training, the individuals who provided the training, the individuals who attended the training

including their professional designation, contents of the education provided.

4) All records will be retained and made available to Inspectors immediately upon request.

Grounds

The licensee failed to ensure that Nursing student #131 administers drugs under the supervision of the member of the registered nursing staff.

Rationale and Summary

During an observation of medication practices, Nursing student #131 prepared and administered medications to resident #013 without the supervision of a registered nursing staff.

Nursing student #131 indicated that they gave medications to residents unsupervised and that Registered Practical Nurse (RPN) #132 was at the nursing station at the time the medication was administered to resident #013. Nursing student #131 was unable to indicate which medications they had just administered.

RPN #132 indicated that they were uncertain of the expectations around supervising students with medication administration.

The DOC confirmed that nursing students are required to be supervised when administering medications to prevent medication errors.

Failure to ensure that Nursing student #131 administered drugs under the supervision of the member of the registered staff, posed a risk to the safety and well being of the residents.

Sources: Observations, interviews with RPN #132, Nursing student #131, and DOC. [741773]

This order must be complied with by May 22, 2024

COMPLIANCE ORDER CO #003 Home to be safe, secure environment

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

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

The licensee shall:

1) Immediately install a keyless entry door lock in all the temporarily converted staff breakrooms, previously used as activity rooms, located in the resident home areas .

2) A member of the management team or delegated registered staff, shall audit daily, for a period of three weeks:
a. The doors to these temporarily breakrooms, in all five units, are kept closed and locked when not in use by the staff.
b. The audits are to be completed daily, on each shift, including weekend days and holidays.
c. Keep a documented record of the audits including the date and time, full name and designation of the individual conducting the audits, results of the audits, and the

corrective actions taken. This record is to be made available to inspectors immediately upon request.

3) Relocate all staff breakrooms to non-resident areas.

4) Once the staff breakroom areas had been relocated, the activity rooms shall be kept with easy access to all residents of the home.

Grounds
The licensee failed to ensure the home is a safe and secure environment when the resident home areas that were converted into breakrooms were not secured as required.

Rationale and Summary

During a PCI, it was observed that in the five resident home areas, the designated activity rooms were converted into breakrooms for the staff.

In each breakroom door there was a sign indicating to please keep the door always closed when the room was not in use. In four of the five converted breakrooms, the door's leaver handle was not locked by the staff when the rooms were not in use. Inside the breakrooms it was observed staff's personal belongings including coats, shoes, backpacks, lunch bags, water bottles, hot/cold beverage mugs, and other consumable food items .

PSWs #120 and #130 indicated the doors for their respective assigned breakroom areas were to be closed but at times staff left it open, and they did not lock the doors when the rooms were not in used.

The ED confirmed it was the home’s expectation to have the designated breakroom doors closed and locked when the rooms were not in used by the staff.
Failure to ensure that resident areas that were converted into temporary staff breakrooms were secured and maintained in a safe state, placed the residents of the home at risk of harm.

Sources: Observations in the home units, interviews with PSWs #120, #130, and ED. [741722]

This order must be complied with by May 22, 2024

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
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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.