Ontario

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

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

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

Public Report

Report Issue Date: February 21, 2025

Inspection Number: 2025-1218-0001

Inspection Type:
Critical Incident
Follow up

Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

Long Term Care Home and City: Riverview Manor Nursing Home, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 4 - 7, 10 - 12, 14, 18 - 21, 2025.

The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:
- Intake: #00129171 - Follow-up #: 1 - O. Reg. 246/22 - s. 74 (2) (e) (i) - Nutritional care and hydration programs. CDD: December 27, 2024
- Intake: #00129174 - Follow-up #: 1 - O. Reg. 246/22 - s. 20 (e) - Communication and response system. CDD: December 31, 2024
- Intake: #00129176 - Follow-up #: 1 - O. Reg. 246/22 - s. 147 (2) (a) - Medication incidents and adverse drug reactions. CDD: December 31, 2024.
- Intake: #00135392 - Follow-up #2 - CO #001, issued under Inspection Report 2024 1218 0002, pursuant to O. Reg. 246/22, s. 12 (1) (3) Doors. CDD: September 13, 2024. RIF $500.00
- Intake: #00115695, #001260, #00129681, #00129953, and #00136645 related to improper care of residents
- Intake: #00123952 – related to financial abuse of a resident.
- Intake: #00125698 – related to verbal abuse of a resident

- Intake: # 00126376 – related to injury unknown origin of a resident.
- Intake: # 00127348 – related to an infectious outbreak
- Intake: # 00127366, #00127376, #00128810, #00130253, #00131236, #00132522, #00136124, and #00137153 – related to physical abuse of residents by residents
- Intake: #00128905 – related to fall of a resident caused an injury
- Intake: #00131880 – related to physical altercation between two residents
- The following intakes were completed in this inspection: intake #00112173 and intake #00124425 were related to falls of residents caused injuries.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1218-0002 related to O. Reg. 246/22, s. 12 (1) 3.
Order #005 from Inspection #2024-1218-0003 related to O. Reg. 246/22, s. 20 (e)
Order #008 from Inspection #2024-1218-0003 related to O. Reg. 246/22, s. 74 (2) (e) (i)
Order #011 from Inspection #2024-1218-0003 related to O. Reg. 246/22, s. 147 (2) (a)

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

Continence Care
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

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

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

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident's rights were treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth, and individuality were respected and promoted when a Personal Support Worker (PSW) rushed and did not provide a proper care to the resident.

Sources: The resident's progress notes, Reinstruction decision document concerning staff, and interview with the resident.

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the care set out in a resident's plan of care provided clear direction to staff and others who provide direct care to the resident when it failed to provide clear directions to staff on interventions for the resident.

Sources: resident's clinical records, LTC home's internal investigation documents, and interviews with staff.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff involved in the care of a resident collaborated with each other in implementing the plan of care for the resident.

A resident was left without care completed for a period of time. Documentation reviewed indicate that the resident had care started and a PSW acknowledged in an interview that they failed to complete care before leaving their shift and did not inform oncoming staff.

The Director of Care (DOC) confirmed that the staff failed to communicate resident's needs, leading to the resident's care interventions not being complete.

Sources LTCH Investigation files, Interviews with PSW and DOC.

WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the care outlined in the plan of care was documented. For a resident documentation was missing during a shift on two separate dates. This period coincided with the resident experiencing an injury of unknown origin.

Sources: Resident's Documentation Survey Report, interview and e-correspondence with acting ED.

WRITTEN NOTIFICATION: When reassessment, revision is required
NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

1.The licensee failed to ensure that a resident's plan of care was reassessed, reviewed and updated when the plan of care was not effective

The plan of care for the resident directs staff with interventions to manage responsive behaviours including to intervene as necessary to protect the rights and safety of others.

Critical incident reports (CIR) involving the resident were submitted to the Director on five separate dates for resident to resident abuse.

The Acting Administrator acknowledged the interventions in place to manage residents behaviours were not effective and the plan of care was not reassessed or updated. Since a specified date the resident has required one on one staffing for evenings to manage behaviours.

Sources: Five critical incident reports, resident's electronic health records, and interviews with staff.

2.The licensee failed to ensure that a resident's plan of care was reassessed, reviewed and updated when the plan of care was not effective.

The plan of care for the resident directs staff with interventions to manage responsive behaviours including to monitor resident from seeking out another specified resident and to redirect them from each other.

Critical incident reports (CIR) involving the resident were submitted to the Director on four separate dates for resident to resident abuse.

Interviews with staff indicated that the resident continues to exhibit responsive behaviours and acknowledged interventions are not successful in preventing physical aggression. The plan of care was not reassessed or updated.

Sources :Four critical incidents, resident's electronic health records, interviews with staff

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 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 failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "emotional abuse" as, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A critical incident report was submitted to the Director, alleging improper care of a resident. The Director of Care (DOC) confirmed that the home's investigation into the incident determined that the home's policy to promote zero tolerance of abuse and neglect of residents was not complied with.

Sources: resident's clinical records, LTC home's internal investigation documents, LTC home's policy, interview with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act
NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (iii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(iii) anything else provided for in the regulations;

The licensee failed to promptly investigate a change of condition for a resident. The resident exhibited a change in condition and the home's investigation was initiated

over 12 days after the original assessment. Interviews with registered staff, the Resident Quality Manager, and the acting Administrator confirmed that the incident was not immediately investigated.

Sources: Resident's health records, Home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director
NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report allegations of improper or incompetent treatment or care of a resident. A review of progress notes indicates that the manager on call was notified immediately at the time of the incident. During an interview, the Director of Care (DOC) acknowledged that the incident should have been reported immediately and confirmed that the report was submitted late.

Sources: A Critical incident report and interview with DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director
NC #009 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.

1.The licensee failed to immediately report allegations of abuse of two specified residents.

The Director of Care (DOC) indicated the allegations of abuse by a resident that occurred on a specified date should have been reported immediately, and acknowledged they were reported late.

Sources: Critical incident report (CIR) and interview with DOC.

.2.The licensee failed to immediately report allegations of abuse of two specified residents.

The Director of Care (DOC) indicated the allegations of abuse were reported by a resident on a specified date should have been reported immediately, and acknowledged they were reported late.

Sources: CIR and Interview with DOC.

WRITTEN NOTIFICATION: Continence care and bowl management
NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 3.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
3. Toileting programs, including protocols for bowel management.

The licensee failed to ensure that a resident's bowel plan was implemented.
A review of a resident's health records identified that they were not administered medications as specified in their bowel protocol.

The Director of Care (DOC) indicated that it is the expectation of the staff to administer medications according to their bowel plan.

Sources: Resident's health records, the home's policy titled Bowel and Bladder Management, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours
NC #011 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; and

1.The licensee failed to ensure that a resident's developed responsive behaviour strategies were implemented when the wander strip was not pulled across the door, while the resident was in the room.

Sources: Observation, the resident's care plan, and interview with the BSO RPN.

2. The licensee failed to ensure that a resident's developed responsive behaviour strategies were implemented when a Personal Support Worker (PSW) attended to the resident alone without ensuring a second staff member was present.

Sources: The resident's care plan, the resident's care profile, the resident's Behavioural Support Assessment, the resident's progress notes, the resident's

witness statements, and interview with the PSW and the Behavioural Support Ontario (BSO) Registered Practical Nurse.

WRITTEN NOTIFICATION: Responsive behaviours

NC #012 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 failed to ensure that actions and interventions were taken to respond to a resident's responsive behaviours when they did not administer medications for agitation and behaviours, or redirect resident from entering a co-resident room resulting in a resident to resident abuse with another resident.

Sources: Two critical Incident reports, resident's health records, interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented. The IPAC Standard

required under section 4.3 that following the resolution of an outbreak, a debrief session was to be conducted to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings was to be used to make recommendations to the licensee for improvements to outbreak management practices. IPAC lead indicated in an interview that no summary of findings or recommendations related to the outbreak was created. E-correspondence with the home also confirmed that there is no documentation from the conclusion of the outbreak.

Sources: Interview with IPAC lead , e-correspondence from acting Executive Director (ED).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #014 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 failed to ensure that the Director was immediately informed of a respiratory outbreak when it was declared by Public Health.

Sources: A Critical incident report, PPH Final Outbreak Investigation Summary.

WRITTEN NOTIFICATION: Orientation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (1) 2.

Orientation
s. 259 (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

The licensee failed to provide training to a Personal Support Worker (PSW) on orientation for safe and correct use of equipment, including therapeutic bath equipment and mechanical lifts.

The Acting Administrator indicated the home's orientation includes training on lifts and transfers but acknowledged that the PSW did not receive this training on hire.

Sources: Email and interview with Acting Administrator.

COMPLIANCE ORDER CO #001 Plan of Care
NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The licensee will create a list of all residents who require slider sheet for all bed repositioning in the south wing.
2. The licensee will conduct an audit to ensure each resident identified as requiring a slider sheet for bed repositioning in the south wing has the necessary equipment available.

3. The licensee will conduct six random audits each week for a period of three weeks to ensure resident #009 is provided assistance with bed mobility as required by the plan of care. Audits should be conducted by a member of the management team, registered staff, or physio, and shall be done across all day, evening and night shifts.
4. The licensee will maintain a written records of the audit conducted, including the name of the person who completed the audit, date and time of the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance; and make them available to Inspectors upon request.

Grounds

1. The licensee failed to ensure that the care outlined in the plan of care was provided to a resident resulting in an injury.

Resident's care plan requires the use of a repositioning aide for when positioning a resident in bed.

The Critical Incident Report (CIR) indicated that staff lacked knowledge of the repositioning aide as per the care plan.

Acting Administrator (AA) acknowledged that staff were not using the repositioning aide and were not following the plan of care. AA concluded that positioning was not done properly.

The home's investigation summary in the investigation notes indicated that staff failing to reposition a resident using their repositioning aide.

Failure to follow the resident's care plan by not using the repositioning aide resulted in injury.

Sources: Resident's care plan, A Critical Incident Report, investigation summary, and interview with AA.

.2. The licensee failed to ensure that a resident's care set out in the plan of care was provided to the resident as specified in the plan when a Personal Support Worker (PSW) provided care to the resident alone.

The resident's care plan indicated two staff for all care and interactions.

The Personal Support Worker (PSW) confirmed that they provided the care to the resident alone and acknowledged that they should have a second staff with them.

The resident stated that they didn't feel good at all when they weren't provided with the care.

Failure to follow the resident's care plan by providing care without the required two staff resulted in compromised care, potential discomfort, and emotional distress for the resident.

Sources: The resident's care plan and interview with the resident and the PSW.

This order must be complied with by May 22, 2025

COMPLIANCE ORDER CO #002 Transferring and positioning techniques
NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

1. The Director of Care or Registered staff designate will complete ten weekly lift, transfer, and repositioning audits each week, for a period of four weeks, to ensure staff are using safe transferring techniques when assisting residents.

2. The lift and transfer audits are to include all types of lifts in the home, bath lifts and repositioning with slider sheets.

3. The audit will document the name of the person who is auditing, the staff members who are being audited, the date, time, and location, and the type of equipment or repositioning aids being used.

4. The audit will also include corrective action and education taken when the lift, transferring or repositioning is not completed in accordance with the home's policies for safe lifting and transferring.

5. Keep a documented record of all audits and corrective action and make available to the Inspectors upon request.

Grounds

1.The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident, resulting in an injury.

An interview with Acting Administrator indicated that improper positioning led to an injury. The home's investigation summary indicated that staff admitted they failed to reposition a resident using repositioning aids.

Failing to ensure safe repositioning techniques were used resulting in a resident receiving injuries.

Sources: Resident's health records, home's investigation notes, interview with Acting Administrator.

2.The licensee failed to ensure that a Personal Support Worker (PSW) used safe transferring techniques when assisting a resident.

A resident reported to the home that PSW transferred them as a one person transfer resulting in injuries.

The Acting Administrator indicated that the expectation of the home is that transfers require two persons and acknowledged that the PSW failed to use safe transferring techniques when assisting the resident without a second person present.

Failing to ensure safe transferring techniques were used resulting in a resident receiving injuries.

Sources: Resident's health records, Home's investigation notes, Policy on Preparing Lifts and Transfers, interviews with staff.

This order must be complied with by May 22, 2025

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Inspection includes one Follow-up #2 - CO #001, issued under Inspection Report 2024 1218 0002, pursuant to O. Reg. 246/22, s. 12 (1) (3) Doors. CDD: September 13, 2024.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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.