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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: February 6, 2025

Inspection Number: 2025-1506-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: St. Joseph's Health System

Long Term Care Home and City: St. Joseph's Health Centre, Guelph, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 - 24, 27 - 31, 2025 and February 3 - 6, 2025

The following intake(s) were inspected:

- Intake: #00137097 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

On January 20, 2025, Inspector observed that the home's visitor policy was not posted as required. The policy was posted later that day.

Sources: Visiting Policy (LTC-052-1) and Visiting Process (LTC-052-3)

Date Remedy Implemented: January 20, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to update a resident's care plan when their feeding assistance needs changed.

Sources: Observation on January 21, 2025, resident's care plan, and interviews with staff.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (c)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

No documentation was made available to residents and their families on how they were going to improve the long-term care home based on the results of the resident and family/caregiver experience survey.

Sources: Resident and Family/Caregiver Experience Survey, and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Documentation

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

Non-compliance with: FLTCA, 2021, s. 43 (5) (d)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part X.

Documentation required in section 45 (b) of the Act was not kept in the long-term care home and made available during the inspection.

Sources: Absence of records, Interview with Family Council President and Interview with DOC.

WRITTEN NOTIFICATION: Duty To Respond

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee failed to respond to concerns or recommendations from Residents' Council in writing within 10 days, multiple times, in the year 2024.

Sources: Resident Council Minutes, Senior Management Response Form for Residents' Council, and interviews with staff.

WRITTEN NOTIFICATION: Duty To Respond

NC #006 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 ensure that they were responding to the concerns or recommendations of Family Council in writing, within 10 days of receiving the advice.

Sources: Family Council Minutes, Senior Management Response Form for Family Council, and interview with DOC.

WRITTEN NOTIFICATION: No Interference By Licensee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 71 (a)
No interference by licensee
s. 71. A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;

The licensee failed to ensure that Family Council's operations were not interfered with, when their Patient and Family Advisory Council recruited potential members of Family Council, provided the same powers to their members, and, conducted the same operations for the home.

Sources: Family Council minutes, St. Joseph Guelph Client & Family Engagement Website, Interview with Family Council President, and staff.

WRITTEN NOTIFICATION: Doors In A Home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the inspection Inspector observed multiple doors to non-residential areas that were open and/or unlocked. Some of these non-residential areas contained equipment that posed a risk to resident safety.

Sources: Observations during inspection, and interviews with multiple staff.

WRITTEN NOTIFICATION: Communication and Response System

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The home failed to ensure that two residents had access to an operational resident-staff communication and response system. Call bells were not operational for an unknown length of time, and the home did not have a process for routinely checking them.

Sources: Observations during inspection, interview with multiple staff.

WRITTEN NOTIFICATION: Air temperature

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2)
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, and in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The home was not measuring or documenting temperatures in the required areas of the home.

Sources: Temperature and humidity logs, interview with the Director of Support Services and Facility Planning and the DOC.

WRITTEN NOTIFICATION: Air temperature

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the air temperature were measured in the required areas of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home was not measuring or documenting air temperatures at least once every morning, afternoon, and evening or night.

Sources: Temperature and humidity logs, interview with the Director of Support Services and Facility Planning and the DOC.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to keep a written record relating to their staffing plan evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Sources: Review of program evaluations, communication with the ADOC.

WRITTEN NOTIFICATION: Bathing

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was offered their bathing method of choice.

A resident preferred baths but was mostly offered showers by staff. Their bathing preference was not documented in their care plan.

Sources: Resident's care plan, interviews with resident and the DOC.

WRITTEN NOTIFICATION: Pain management

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to ensure that the residents' responses to, and the effectiveness of, the pain management strategies were monitored. A resident received scheduled pain medications and staff had not documented the resident's response to these interventions.

Sources: Interview with staff, resident's pain assessments, vital signs history, and administrated record, the home's, Pain & Palliative Program Policy LTC-012-3.

WRITTEN NOTIFICATION: Dining and snack service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure the home had a dining service that ensured foods are being served at a temperature that is both safe and palatable to the residents.

The dietary staff did not monitor the temperature of cold menu items. By not monitoring the temperature of these items prior to meal service there is a risk that food items be served at a temperature that is not safe or palatable.

Sources: Lunch observation, The home's policy titled 'Procedure for Food Safety (Food Temperatures) and interviews The Food Services Manager and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

Program

NC #016 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 issued by the Director was complied with.

a) In accordance with Additional Requirements 9.3 under the IPAC standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure a staff member wore the required Personal Protective Equipment (PPE) when assisting a resident on additional precautions.

Sources: Observations during inspection, Additional Precaution Signage, and interviews with multiple staff.

b) In accordance with Additional Requirements 7.3 under the IPAC standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure audits completed regularly were able to tell if staff could perform IPAC skills required of their role. Audits did not contain names of the staff being observed.

Sources: Audits, and Interview with IPAC Associates.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that drugs are destroyed and disposed of in a safe and environmentally appropriate manner. Staff stated they discard of liquid medications by pouring them down the sink. The clinical pharmacist consultant at the home stated no medication should be poured down the drain because it contaminates the groundwater supply.

Sources: Interviews with Registered staff and the clinical pharmacist consultant, policy titled Medication Destruction and Disposal Guidelines, Guidelines for Non-Narcotic/Controlled Medications Disposal.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (3) (b)
Drug destruction and disposal
s. 148 (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care.
O. Reg. 246/22, s. 148 (3); O. Reg. 66/23, s. 31.

The licensee failed to ensure two staff members were present during the destruction and disposal of non-controlled substances. Staff stated they place these substances in a one-way bin and lock it when three-quarters full, without a second staff member present. The Director of Care stated that staff should sign off on this task, but this documentation is not currently in place.

Sources: Interviews with Registered staff and the Director of Care, policy titled Medication Destruction and Disposal (non-Narcotic/Controlled medications).

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee failed to ensure that the continuous quality improvement committee is composed of every designated lead of the home, as the BSO Lead was not a member.

Sources: LTC PAC Meeting Minutes 2024-2025, and Interview with staff.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.

Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that the continuous quality improvement committee is composed of at least one employee who is a member of the regular nursing staff of the home.

Sources: LTC PAC Meeting Minutes 2024-2025, and Interview with staff.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #021 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that the continuous quality improvement committee is composed at least one employee who has been hired as a personal support worker (PSW) or provides personal support services at the home and meets the qualifications of personal support worker as referred by the Act and it's regulations.

Sources: LTC PAC Meeting Minutes 2024-2025, and Interview with staff.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #022 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee did not have a report on the continuous quality improvement initiative prepared for the long-term care home as required.

Sources: Organizational QIP Narrative Report, Email communication and interviews with staff.

WRITTEN NOTIFICATION: Orientation

NC #023 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (b)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(b) modes of infection transmission;

The licensee failed to ensure that education on the modes of infection transmission were included in the training and orientation of newly hired staff.

Sources: SJHCG IPAC Orientation, email communication and interview with staff.

WRITTEN NOTIFICATION: Orientation

NC #024 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee failed to ensure that education on signs and symptoms of infectious diseases were included in the training and orientation of newly hired staff.

Sources: SJHCG IPAC Orientation, email communication and interview with staff.

WRITTEN NOTIFICATION: Orientation

NC #025 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The licensee failed to ensure that education on respiratory etiquette was included in the training and orientation of newly hired staff.

Sources: SJHCG IPAC Orientation, email communication and interview with staff.

WRITTEN NOTIFICATION: Orientation

NC #026 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The licensee failed to ensure that education on what to do when experiencing symptoms of infectious diseases were included in the training and orientation of newly hired staff.

Sources: SJHCG IPAC Orientation, email communication and interview with staff.

WRITTEN NOTIFICATION: Orientation

NC #027 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee failed to ensure that education on handling and disposing of biological and clinical waste including used PPE were included in the training and orientation of newly hired staff.

Sources: SJHCG IPAC Orientation, email communication and interview with staff.

WRITTEN NOTIFICATION: Orientation For Volunteers

NC #028 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 263 (2) 3.
Orientation for volunteers
s. 263 (2) For the purposes of clause 83 (f) of the Act, the following are the other areas on which information shall be provided:
3. Infection prevention and control, including what is set out in subsection 259 (2).

The licensee failed to ensure that multiple areas set out in subsection 259 (2) of O. Reg. 246/22 were included in the orientation of volunteers as required. Specifically, orientation did not include: modes of transmission, signs and symptoms of infectious disease, cleaning and disinfection practices, use of personal protective equipment (PPE) including appropriate donning and doffing, and the handling and disposing of biological and clinical waste including PPE.

Sources: Volunteer Orientation Package 2025, and Interview with Volunteer Coordinator.

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #029 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 17.
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:
17. Every resident has the right to be told both who is responsible for and who is providing the resident's direct care.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Ensure that a procedure is developed and implemented that instruct staff on what to do when their name badge is either damaged, lost, misplaced and/or otherwise unavailable while required to be worn.
b) Educate all staff who provide direct care on this procedure. A record of the education must be kept in the home, and contain the following: the time and date the education was provided, who provided the education, the name of the staff educated, their designation, and a signature by the staff educated for attestation.
c) Complete an audit to ensure all staff who are assigned to provide direct care on a specific home area are wearing their name badge. This audit must be completed on every resident home area, at the start of every shift for at minimum 14 days consecutively and until compliance is met. The audit must be documented and kept in the home. The audit must contain the following: the date and time the audit was conducted, the name of the auditor, the home area, the staff assigned and the staff audited. The audit must also identify any staff who do not have their name badge for that shift and any actions taken as a result. If the auditor is also providing direct care, they must sign and attest that they are also wearing their name badge.

Grounds

The licensee failed to ensure residents are told who is responsible for and who is providing their direct care, when staff do not wear their required name badges.

During the inspection multiple staff were observed to not be wearing a name badge when providing direct care to residents. Staff interviewed indicated that their name tags were either broken, lost, or misplaced and that they had taken no actions to replace or identify themselves in the meantime. In one instance, staff said a name badge was not used for approximately six months of time. Family council has raised concerns regarding this since 2021 with no resolution. A resident said that this has

been a problem for a long time and that the majority of staff do not wear their name badge. They expressed concern of other residents, and themselves, in not knowing who is providing care.

Sources: Family Council Minutes, Family Council Concern Form, Observations during inspection, Interview with a resident and multiple staff.

This order must be complied with by March 17, 2025

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.