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

Ottawa District
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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 30, 2024	
Inspection Number: 2024-1507-0002	
Inspection Type: Complaint Critical Incident	
Licensee: The Religious Hospitallers of St. Joseph of Cornwall, Ontario	
Long Term Care Home and City: St. Joseph's Continuing Care Centre, Cornwall	
Lead Inspector Jessica Nguyen (000729)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-28, 2024, and April 2-3, 9-10 and 12, 2024.

The following intake(s) were completed in this complaint inspection:

- Intake #00107816 was related to a bed refusal.
- Intake #00111782 was related to death of a resident.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00110879 / CI#3012-000007-24 was related to an alleged staff to resident verbal / emotional abuse.
- Intake: #00111759 / CI#3012-000009-24 was related to an alleged staff to resident physical abuse.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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 the home's Policy: Zero Tolerance of Abuse and / neglect of residents and patients was complied with for a resident.

Summary and Rationale

A resident reported to a Registered Nurse (RN) an incident of alleged abuse towards them by a Personal Support Worker (PSW). A review of the resident's electronic record confirmed that they RN charted they first noticed impaired skin integrity on the resident that night.

No assessment was completed by the RN when they were made aware of the incident. The resident was later assessed by an RPN and a NP.

According to the licensee's Policy 4-a-1, Zero Tolerance of Abuse and / neglect of residents and patients, last revised on May 03, 2022, the Registered staff responsible for the care of the resident harmed by the abuse or neglect should conduct a head-to-toe physical assessment on the alleged victim and document findings if physical abuse is alleged. The policy also stated to call physician or other health practitioners for further assessment based on nursing assessment. The primary physician or Nurse Practitioner (NP) was not contacted and no head-to-toe assessment was completed as per policy.

Chief Nursing Executive (CNE) confirmed that the resident was not immediately assessed for injury by the RN and was later assessed by the NP.

Along with the above, the following components of the licensee's policy of Zero Tolerance of Abuse and neglect were not complied with and issued separately under their specific legislative reference:

a) FLTCA s. 28 (1) 2- Reporting certain matters to Director, according to the licensee's policy, when following the decision trees for reporting emotional and physical abuse, licensee is required to immediately report to the Director via CIS or after-hours number if outside of business hours.
b) FLTCA s. 27 (1) a) (i)- Licensee must investigate, respond, and act to any allegation of abuse, according to the licensee's policy, when following the decision trees for reporting emotional and physical abuse, licensee is required to immediately investigate and take action in response to incident.
c) O. Reg 246 / 22 s.104 (1)- Notification re incidents, according to the licensee's policy, SDM should be notified within 12 hours upon the licensee becoming aware of

any alleged abuse.
d) O. Reg 246/22 s. 105- Police notification, according to the licensee's policy police are to be notified if it is thought that an alleged, suspected or witnessed incident of abuse or neglect of a resident may constitute a criminal offence.
e) O. Reg 246/22 s.106- Evaluation, according to the licensee's policy, the home's policy is to be reviewed annually.

By not ensuring that the written Policy: Zero Tolerance of Abuse and/neglect of residents and patients was complied with, the resident was placed at higher risk of further harm/injury.

Sources:

Internal investigation notes.
Resident's electronic records.
Interview with CNE.
Policy 4-a-1: Zero Tolerance of Abuse and/neglect of residents and patients. Last revised 03 May 2022.

[000729]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
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:

(i) abuse of a resident by anyone,

The licensee has failed to ensure that the alleged incident of abuse of a resident that the licensee was made aware of was immediately investigated.

Summary and Rationale

A) On a specific date, a resident reported to an RN an incident of alleged abuse towards them by a PSW. An investigation was not initiated immediately.

CNE confirmed that when the incident of alleged abuse towards resident was reported to the RN, they did not report the incident to management and therefore no investigation was initiated. The investigation was initiated during the next shift by management.

Failing to ensure that an immediate investigation was initiated, the resident was placed at risk of abuse reoccurring and having an alleged incident of abuse towards them investigated late.

Sources:

Resident's electronic record.
Internal investigation notes.
Interview with CNE.

[000729]

The licensee has failed to ensure that the alleged incident of abuse of a resident that the licensee was made aware of was immediately investigated.

Summary and Rationale

B) On a specific date, two separate incidents of alleged abuse by a PSW towards a resident was witnessed by a Recreation Staff and a PSW and was not reported to management until days later at which time the investigation was initiated.

CNE confirmed that based on the licensee's Zero Tolerance of abuse and neglect policy, both staff should have reported the alleged incident immediately to the registered staff, who should have reported to management on duty, and they should have reported to the Director by calling the after-hours line and an investigation should have been initiated immediately.

By not ensuring that an immediate investigation was initiated, the resident was placed at risk of the abuse reoccurring and having an alleged incident of abuse towards them investigated late.

Sources:

Internal investigation notes.
Interview with CNE.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised on 03 May 2022.

[000729]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (b)
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,
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;

The licensee has failed to provide a written notice with a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care when withholding admission of a resident to the home.

Summary and Rationale

An applicant was sent a refusal letter from the licensee outlining the reasons for their refusal of admission. In the written notice, the licensee did not provide a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care.

Nursing Care Coordinator (NCC) confirmed they were not aware of all the requirements for the written notice when a licensee withholds admission and confirmed that the refusal letter sent to applicant, did not meet all the requirements as outlined in legislation. NCC was not able to provide a detailed explanation on how the home lacked the nursing expertise necessary to meet the applicant's care requirements.

The written notice provided to the applicant when withholding admission to the home did not meet requirements outlined in legislation.

Sources:

Refusal letter.
Applicant's application package.
Interview with NCC.

[000729]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 103 (b)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

The licensee has failed to have a written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents that contains procedures and interventions to deal with persons who have abused or allegedly abused residents, as appropriate.

A) A resident reported to an RN an incident of alleged abuse towards them by a PSW. After being made aware of the incident of alleged abuse towards the resident, RN did not report the incident or take any actions towards the involved employee in order to protect and ensure the safety of the resident. The involved employee continued to provide care to residents for the remainder of their shift.
Review of the licensee's policy Zero Tolerance of Abuse and neglect indicated no

clear procedure or interventions to deal with the involved employee who may have abused or allegedly abused a resident. The policy states the involved employee is to document details regarding incident, cooperate during investigation, seek counseling, and maintain confidentiality but no steps regarding what to do with the involved staff to ensure safety of the residents. The policy also states that employees who have witnessed or suspect alleged incident, should intervene, if safe to do so, or identify needed interventions to ensure safety or residents but there is no clear procedure or interventions listed. Due to unclear direction in the licensee's policy, the involved employee continued to provide care to residents.

Failure to have a written policy that contains procedures and interventions to deal with persons who have abused or allegedly abused residents put residents at risk for further harm / injury.

Sources:

Resident's electronic records
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last reviewed 03 May 2022.

[000729]

The licensee has failed to have a written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents that contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

B) On a specific date, two separate incidents of alleged abuse by a PSW towards a resident were witnessed by a Recreation Staff and a PSW. During interviews it was confirmed the incidents were not reported to management until days later, and

therefore no immediate actions were taken towards the involved employee in order to protect and ensure the safety of the resident. The involved employee was continued to provide care to residents for the remainder of their shift.

Review of the licensee's policy Zero Tolerance of Abuse and neglect indicated no clear procedure or interventions to deal with the involved employee who have abused or allegedly abused a resident. Due to unclear direction in the licensee's policy, the involved employee continued to provide care to residents for the remainder of their shift.

Failure to have a written policy that contains procedures and interventions to deal with persons who have abused, or allegedly abused residents put residents at risk for further harm / injury.

Sources:

Interview with Recreation staff and PSW.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.

[000729]

WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (1)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged,

suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) were notified within 12 hours upon the licensee becoming aware of the witnessed incident of abuse of a resident.

Summary and Rationale

A) On a specific date, two separate incidents of alleged abuse by a PSW towards a resident was witnessed by a Recreation Staff and a PSW and was not immediately reported to their SDMs.

The incidents were witnessed on a specific date and were reported to management days later and SDM was notified several days after incident. This was not completed within the 12 hours time frame as required per legislation.

CNE confirmed that the resident's SDM was notified of the incident of alleged abuse on a specific date, several days after incident and again after investigation was completed.

Sources:

Internal investigation notes.
Interview with CNE.
[000729]

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of the alleged incident of abuse of resident that resulted in physical injury or pain to the resident.

B) A resident reported to an RN an incident of alleged abuse towards them by a PSW. After being made aware of the incident of alleged abuse towards the resident, the RN did not report the incident to the SDM immediately as required by legislation.

CNE confirmed that the resident's SDM was notified of the incident of alleged abuse towards resident outside of the timeframe required by legislation.

Sources:

Resident's electronic record.
Interview with CNE.

[000729]

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246 / 22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged incident of abuse towards a resident.

Summary and Rationale

A) Resident #004 reported to an RN an incident of alleged abuse towards them by a PSW. After being made aware of the incident of alleged abuse towards the resident, the RN did not report the incident to the appropriate police service.

Review of Critical Incident (CI) # 3012-000009-24 confirmed that the appropriate police force was not notified of incident.

According to licensee's policy of Zero Tolerance of Abuse and neglect police are to be notified if it is thought that an alleged, suspected or witnessed incident of abuse or neglect of a resident may constitute a criminal offence and that all incidents of physical abuse that cause physical injury must be reported to police and MLTC. This was not completed; police were never notified of the incident.

CNE confirmed that the incident of alleged abuse towards the resident was reported to the RN, and they did not report the incident to the appropriate police force.

Failing to ensure that the appropriate police force was immediately notified of an incident that may constitute a criminal offense puts the resident at risk of the incident towards them going unreported.

Sources:

CI # 3012-00009-24.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.
Interview with CNE.

[000729]

The licensee has failed to ensure that the appropriate police force was immediately notified of a witnessed incident of abuse towards a resident.

B) On a specific date, two separate incidents of alleged abuse by a PSW towards a resident was witnessed by a Recreation Staff and a PSW was not immediately reported to appropriate police force.

According to the licensee's policy: Zero Tolerance of Abuse and neglect, police are to be notified of incident if it is thought an alleged, suspected or witnessed incident of a resident may constitute a criminal offence. The appropriate police were not notified of incident.

Review of CI# 3012-000007-24 confirmed that the appropriate police force were not notified of the incident.

During separate interviews, both staff confirmed that after witnessing an incident of alleged abuse by a PSW towards a resident, they did not report the incident to anyone including the appropriate police force.

Failing to ensure that the appropriate police force was immediately notified of an incident that may constitute a criminal offense puts the resident at risk of the incident towards them going unreported.

Sources:

CI # 3012-00007-24.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.

[000729]

WRITTEN NOTIFICATION: Evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 106 (b)
Evaluation
s. 106. Every licensee of a long-term care home shall ensure,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

The licensee has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents, and determine what changes and improvements are required to prevent further occurrences.

Rationale and Summary

At the time of inspection, CNE provided inspector with the home's Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. This policy was last revised on May 03, 2022 and an evaluation and up to date policy was not provided. The licensee's policy makes legislative reference to the Long-Term Care Homes Act, 2007 and O. Reg 79 / 10 instead of the Fixing Long-Term Care Act, 2021 and O. Reg 246 / 22.

Failing to evaluate at least once in a calendar year the effectiveness of the licensee's policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents and referencing out of date legislation poses gaps in

determining areas of improvement and needed change to prevent further occurrences.

Sources:

Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.

[000729]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
To ensure compliance the licensee must:

1) Develop and make readily available a written process to ensure that all staff are trained on the immediate actions to be taken after an incident of alleged, witnessed or suspected resident abuse to ensure that all residents are protected and safe in the home.

This process should include but is not limited to:
- Clearly defined roles, responsibilities, and timelines for all staff to ensure the safety of all residents anytime there is an alleged, witnessed, or suspected incident of abuse.

2) Recreational staff, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), PSW Supervisor, Nursing management and any other relevant staff members that would be involved in the process will be educated on the process developed.

3) Written records of the training provided including the date it was provided and the signature of the staff members who received the training, shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds:

The licensee has failed to protect a resident from abuse by a staff member.

A) On a specific day, a resident reported to a RN an incident of alleged abuse towards them by a PSW. At this time, the RN charted that the resident was accusatory towards the PSW and that they noted impaired skin integrity on the resident. After being made aware of the incident of alleged abuse towards the resident, the RN did not immediately take any actions to protect and ensure the safety of the resident.

The resident confirmed that the incident of alleged abuse occurred during care / toileting, and was reported to the RN a few hours after. Despite the resident reporting the incident to two PSWs and the RN, no staff member took any actions to protect or ensure the safety of the resident.

Chief Nursing Executive (CNE), confirmed that the RN did not take any immediate actions to protect the resident and that the resident was not assessed by the NP for injury until later that day. The involved staff member continued to provide care for the remainder of their shift.

Failing to take immediate actions after an allegation of abuse put the residents at risk of harm and another incident of abuse occurring.

Sources:

Internal investigation notes.
Resident's electronic records.
Interviews with Resident, PSW and CNE.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.

[000729]

The licensee has failed to protect resident from alleged abuse by a staff member.

On a specific date, two separate incidents of alleged abuse by a PSW towards a resident was witnessed by a Recreation Staff and a PSW and was not reported and no immediate actions were taken to protect or ensure the safety of the resident.

The incidents occurred at a specific time on a specific date and and were not reported to management until days later, at which time the investigation was initiated.

The recreation staff and PSW confirmed that after witnessing separate incidents of alleged abuse by a PSW towards the resident, they did not report the incidents immediately to the Director. Since registered staff and management were not made aware of the incident no immediate actions were taken to protect the resident. The alleged staff member continued to provide care for the remainder of their shift. Since no immediate actions were taken after the first incident, a second incident was permitted to occur.

Failing to take immediate actions after a witnessed incident of abuse put residents at risk of harm and another incident of abuse occurring.

Sources:
Internal investigation notes.
Interviews with Recreation staff, PSW, and CNE.
Policy 4-a-1: Zero Tolerance of Abuse and / neglect of residents and patients. Last revised 03 May 2022.

[000729]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
To ensure compliance the licensee must:

1) Develop and make readily available a written process to ensure that all staff are trained on the reporting requirements and legislative timeline related to any incident

of alleged, witnessed or suspected resident abuse.

This process should include but is not limited to:

- Clearly defined roles, responsibilities, and timelines for all staff specifically related to reporting alleged, suspected, or witnessed resident abuse.
- Ensure all staff are familiar with the following: who to report incidents of abuse to; based on their role, what meets the definition of abuse and needs to be reported, timeline for immediate reporting, how and where to report abuse to the Director during regular hours and after hours.

2) Recreational staff, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), PSW Supervisor and Nursing management and any other relevant staff members that would be involved in the process will be educated on the process developed.

3) Written records of the training provided including the date it was provided and the signature of the staff members who received the training, shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds:

The licensee has failed to ensure that the alleged abuse of a resident by staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

A) Critical Incident System report (CIS) # 3012-000007-24 was related to the alleged abuse of a resident by a PSW. Two separate incidents were witnessed on a specific date by a recreation staff and a PSW. The CIR was submitted to the Director

several days after incident and the after-hours line was not called.

CNE confirmed that both staff should have reported the alleged incident immediately to the registered staff, who should have reported to management on duty and they should have reported to the Director by calling the after hours line and a CIS would be completed on the next business day. These steps were not followed.

Failure to immediately notify the Director of the alleged abuse puts residents at risk of additional harm.

Sources:

CI #3012-000007-24.
Interview with CNE.

[000729]

The licensee has failed to ensure that the alleged abuse of a resident by staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

B) CI # 3012-000009-24 was related to the alleged abuse of a resident by a PSW that occurred during care that resulted in impaired skin integrity. The incident was reported to the RN at a specific time on the date of the incident and the CI was not submitted to the Director until several hours later and the after-hours line was not called.

CNE confirmed that the incident was reported to the Director late.

Failure to immediately notify the Director of the alleged abuse places residents at risk of additional harm.

Sources:

CIS report #3012-000009-24.
Interview with CNE.

[000729]

This order must be complied with by July 12, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.