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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Amended Public Report (A2)

Report Issue Date September 28, 2022
Inspection Number 2022_1094_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________________

Licensee
Lutheran Homes Kitchener-Waterloo

Long-Term Care Home and City
Trinity Village Care Centre, Kitchener

Inspector who Amended
Janis Shkilnyk (706119)

Inspector who Amended Digital Signature

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This licensee report has been amended to reflect a change to CO #001. The complaint, critical incident summary inspection, inspection #2022_1094_0001 was completed on August 15-30, 2022, offsite: August 18, 19, 29, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15-30, 2022, offsite: August 18, 19, 29, 2022.

The following intake(s) were inspected:

Log #: 014319-22, Log #: 0143192-22, Log #: 013713-22, Log #: 013511-22, Log #: 013238-22, Log #: 013195-22, Log #: 013023-22, Log #: 012709-22, related to no registered nurse in the building.

Log #: 014114-22, Log #: 014039-22, Log #: 006243-22, Log #: 006173-22, Log #: 005997-22, Log #: 020766-21, Log #: 018921-21 related to a fall of a resident resulting in an injury.

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Log #: 012217-22 Complaint related to concerns regarding plan of care and falls for a resident
Log #: 012073-22 related to concerns regarding improper care of a resident.

Log #: 011065-22 Complaint related to care of residents not being completed.

Log #: 006794-22 related to improper management of medication for a resident and was admitted to hospital.

Log #: 003163, Log #: 018152-21, Log #: 017711-21 related to the unexpected death of a resident.

Log #: 021068-21, Log #: 017207-21, Log #: 015589-22 related to allegations of staff to resident abuse.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION DUTY TO PROTECT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 19 (1)

The licensee has failed to ensure that a resident was protected from abuse by staff.

“Physical abuse” is defined as the use of physical force by anyone other than a resident that causes injury or pain. O. Reg. 79/10, s. 2 (1).

Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

Rationale and Summary

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Staff members were attempting to provide care to a resident and the resident was resisting the care being provided. During the provision of care, a staff member was physically aggressive towards the resident.

This incident of physical abuse caused minimal harm to a resident as they did not sustain any physical injuries and there were no long-term effects in regard to the resident's emotional well-being; however, the resident was emotionally distressed when the incident occurred.

Sources:

Interviews with staff, staff statements from Trinity Village Care Centre's internal investigation notes, Notice of Termination of Employment – Without Prejudice documentation.

[741123]

WRITTEN NOTIFICATION INVOLVEMENT OF RESIDENT, ETC.

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 S. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care when they were not notified of a resident's change of condition.

Rationale and Summary

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to concerns that a substitute decision maker had not been informed of a change of condition for a resident.

A resident's documentation indicated they experienced a change in their health status. The substitute decision maker (SDM) was not notified.

The Acting Director of Resident Care (Acting DORC) confirmed that the SDM was not notified related to a change of condition for the resident and should have been.

When the home did not notify the SDM of the resident's change of condition it may have delayed the SDM's participation in the development of the plan of care.

Sources:

Interviews with Acting DORC, registered staff, review of resident clinical records, home's investigative notes.

[706119]

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

WRITTEN NOTIFICATION DUTY OF LICENSEE TO COMPLY WITH PLAN

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.6 (7)

The licensee has failed to ensure that a resident received specified care was provided to the resident as per their plan of care.

Rationale and Summary

A complaint was received which alleged resident care was documented as completed but residents did not receive the required care.

The resident was nonverbal and had severe cognitive impairment.

The resident's plan of care documented specific care preferences.

Care documentation showed that on multiple occasions specified care was not provided as required.

A registered staff said there was concern from another shift's staff during a specific time period, that the residents were missing specified care. The registered staff notified the Nursing Resource Lead.

Failure to follow the resident's plan of care with respect to residents specified care put the resident at risk for discomfort and potential skin breakdown.

Sources:

Complaint log #, Care plan, Documentation survey report, interviews with registered staff

[659]

WRITTEN NOTIFICATION GENERAL REQUIREMENTS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 34 (2)

The licensee has failed to comply with the documentation of the head injury routine assessment for a resident post fall.

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

In accordance with O. Reg 246/22 s. 11. (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Specifically, the staff did not comply with the licensee's policy Head Injury, reviewed date: February 2021, which stated that a resident on head injury routine check must be woken if not awake, if resident refuses please document the refusal. The policy outlines the requirements for completion of the Head Injury Routine. The policy also directs staff to complete the HIR for an unwitnessed fall.

A) **Rationale and Summary**

A resident had an unwitnessed fall. The Head Injury Trend Routine form for the resident was started. The HIR documented the resident as sleeping on five occasions during the night. An assessment of each of these times was to have included for the resident, monitoring of blood pressure, pulse, respiration rate, pupil size, response for left and right eye, motor response for left and right arm and leg, level of consciousness, blood thinner and, if the resident was on a narcotic.

The Acting Director of Resident Care (Acting DORC) confirmed residents are to be woken up if sleeping to complete a head injury routine and that the resident had not had a Head Injury completed per the home's policy.

The home's failure to complete the head injury routine for a resident risked a potential delay in treatment and alerting staff of a worsening head injury for the resident.

Sources:

Interview with Acting DORC, clinical record review for a resident, Head Injury Trend form for a resident, Policy-Head Injury Routine, reviewed date: February 2021, DOCit documentation

[706119]

Non-compliance with: O. Reg. 79/10, s. 30 (2)

B) **Rationale and Summary**

A resident had self reported fall. The Head Injury was to have been completed for 72 hours post fall. There was no documentation of a Head Injury routine having been completed.

A registered staff confirmed that a head injury routine was to be completed for a resident who had fallen, reported they had fallen, or had an unwitnessed fall. The registered staff member confirmed no head injury routine was completed for the resident who self reported an unwitnessed fall.

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

The home's failure to complete the head injury routine for the resident risked a delay in treatment and potential worsening of a head injury for the resident.

Sources:

A resident's progress notes, Head Injury Routine documentation on DOCit, Home Policy, interview with registered staff and Acting DORC.

[741750]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident had documented alterations in skin integrity, that they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

The post hospitalization Head to Toe Assessment for a resident identified five areas of altered skin integrity. The resident had been admitted to the hospital and treated with medication for a specific medical condition. This medication was prescribed upon return from hospitalization for the resident.

A registered staff confirmed that a resident with a specific medical condition should have a skin and wound assessment completed when alteration in skin integrity is identified.

The home's policy titled with the specific medical condition, directed staff of signs/symptoms of that specific medical condition that included specific signs and symptoms to monitor for.

The home's failure to complete a skin and wound assessment for the resident could have impacted treatment and led to impaired healing of the altered skin integrity.

Sources:

Interview with Acting DORC, registered staff, record review of the resident, review of assessments in point click care, policy- of specific medical condition, date revised: June 2013

[#706119]

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with when staff were observed not wearing the recommended Personal Protective Equipment (PPE) in an area of the home declared in a disease outbreak.

Rationale and Summary

The home was experiencing an infectious disease outbreak with several resident home areas in outbreak.

Public Health Ontario technical brief Interim Infection Prevention and Control (IPAC) Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19 9th Revision: June 2022, documented that for every patient and/or patient environment encounter, apply the Four Moments for Hand Hygiene, universal masking with well-fitted medical masks for source control (i.e., to protect others from the mask wearer) and routine use of eye protection. Eye protection includes goggles and face shields.

Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities Version 1.0 June 10, 2022, documented that all health care workers providing direct care to or interacting with, a suspect or confirmed case of COVID-19 should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit-tested, seal-checked N-95 respirator (or approved equivalent).

Public Health Ontario donning and doffing signage for PPE was observed on resident room doors for all residents with confirmed or suspected Covid 19. The home provided staff with a booklet that included the steps for donning and doffing of PPE. These steps were the Public Health Ontario Posters for donning and doffing. The steps documented for removing PPE were to remove gloves, remove gown or arm barrier, perform hand hygiene, remove eye protection, remove mask or N95 respirator and perform hand hygiene. The booklet instructed staff to follow all signage as posted.

Trinity Village Care Centre, July 6th, 2022, Visitors Policy-Protecting Yourself and protecting Trinity Village Care Centre-guidelines stated visitors were to wear the provided surgical mask at all times as well as face shield and other personal protective equipment if required.

Electronic information provided on the home's website-Trinity Village Care Centre update-August 15, 2022, stated eye protection and N-95 respirator should be worn at all times on all of the home areas, full donning and doffing of PPE in all resident rooms.

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

A resident home area was declared in an infectious disease outbreak. Staff in this home area were observed not wearing a N-95 respirator or eye protection. Another staff was observed not wearing eye protection. Both were assisting residents in the dining room.

On a different resident home area which was also in an infectious disease outbreak, two staff were observed not wearing eye protection or N-95 respirator in the resident dining room. Two contract workers were observed in this resident home area not wearing eye protection or face shields.

One entrance to a resident home area in an infectious disease outbreak had no hand sanitizer, PPE or garbage receptacle available prior to entering or exiting the resident home area for donning or doffing of PPE equipment.

A registered staff was observed entering a non-outbreak resident home area wearing a N-95 respirator and eye protection after being on the outbreak resident home areas throughout their shift. The staff member had not doffed their N-95 respirator after exiting a resident home area that was in an infectious disease outbreak. They were not observed wearing a face shield.

Inspector #741771 observed staff not wearing a mask or eye protection, several other staff were not wearing eye protection in a resident home area declared in an infectious disease outbreak.

During an interview staff stated the home was out of their size for N-95 respirator and that they did not know that wearing eye protection in the dining room with residents present was required during an infectious disease outbreak.

Registered staff confirmed that all staff caring for residents directly and anyone entering a resident home area declared in an infectious disease outbreak were to wear a N-95 respirator and eye protection.

The Infection Control Practitioner IPAC Hub confirmed that PPE use in a declared outbreak area for the health care worker providing direct care should include donning gowns, gloves, eye protection, and a fit-tested, seal-checked N-95 respirator in Droplet/Contact areas. Donning/doffing steps may differ based on the eye-protection being used. If a health care worker were to be using a face-shield as eye-protection then an N-95 respirator can be kept on so long as: the face-shield is being disinfected between resident interactions, they are not leaving the designated outbreak area with that respirator, and that the respirator is not soiled or has not been adjusted, or touched, many times. If the health care worker chooses to wear goggles/glasses this would change to donning/doffing at the appropriate steps (i.e., between all resident interactions, if soiled, leaving the designated outbreak area).

A staff member stated that they did not change their N-95 respirator throughout the shift when entering and exiting a positive/suspect infectious disease resident room to provide direct care. They stated the eye protection they used was googles.

The home's failure to ensure staff wore Personal Protective Equipment as outlined in standards and protocols issued by the Director in areas of the home declared in an infectious disease outbreak may have led to further spread of the infectious disease.

Sources:

Public Health Ontario, TECHNICAL BRIEF Interim IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19, 9 th Revision: June 2022, Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities Version 1.0 June 10, 2022, Interviews with IPAC Lead, Infection Control Practitioner IPAC Hub, staff, staff observations, Visitors' policy, July 2022, Trinity Village Care Centre update-August 15, 2022, Trinity Village Care Centre Team Trinity Care Code, Version: 2022-2023

[706119]

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 114 (1)

The licensee has failed to comply with their medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents when a resident's quarterly medication review was not processed correctly.

In accordance with O. Reg. 79/10 s. 8. (1) (b), the licensee shall ensure when a quarterly review is completed by the Physician, the Nurse Manager will check it for new orders and transcribe new orders to the Medication Administration Record (MAR) or delete discontinued or changed orders on the MAR sheet. If the review is done near the end of the month, the MAR sheets for the coming month must also be checked and changes added or deleted as required.

Rationale and Summary

A resident's quarterly medication review for a specific quarter, documented a physician order written on a specific date, that directed staff to call the Nurse Manager for a specific blood pressure reading, and repeat and if over the specified parameter, to call the Medical Doctor (MD). The order had not been processed and transcribed to the resident's electronic medication administration record (EMAR).

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

The Acting Director of Care (Acting DORC) confirmed that an order written for a specific parameter of blood pressure reading, by the physician had not been processed to the next quarterly medication review or EMAR and should have been for the resident.

Interviews with several registered staff described using different parameters for when a physician should be called regarding a change in the resident's blood pressure reading. Registered staff interviewed were not aware of the physician order to be called when the resident blood pressure reading was greater than the parameters specified on the quarterly medication review.

The home's failure to follow their quarterly medication review process could have led to potential risk of harm to the resident by not providing staff with clear direction on their medical condition and a potential delay in treatment for the resident related to their medical condition.

Sources:

Interviews with Acting DORC, registered staff, review of resident's clinical records, EMAR, Quarterly Medication Reviews policy date revised: June 2013

[706119]

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 54 (2)

The licensee has failed to ensure that when a resident fell a post fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall in their room. They were found by staff. Documentation stated there was no injury to the resident from this fall.

There was no post fall or near miss investigation note documented.

The Acting Director of Resident Care (ADORC) stated it was the home's policy that the post fall investigation was to be completed.

Not completing a post fall assessment for the resident was a missed opportunity for the home to compare and analyze trends in the resident's falls and potentially implement additional interventions for fall prevention for the resident

Sources:

Progress notes, care plan, assessments, risk management, interviews with ADORC and staff.

#659

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

The Licensee has failed to comply with s. 24 (1) (2) of O. Reg. 79/10

Rationale and Summary

Staff witnessed use of excessive force by one staff member towards a resident when providing care. The staff member did not report the incident until several days later. Other staff involved did not report the incident until the home started their investigation several days later.

One staff member reported the incident to the Human Resources manager, seven days after the incident of physical abuse occurred which delayed the home reporting the incident to the Director.

By staff not immediately reporting the incident of alleged physical abuse from staff towards a resident, there was a risk that the home would not have been able to immediately respond and address the allegation.

Sources:

Interviews with staff and ADORC, staff statements from Trinity Village Care Centre's internal investigation, critical incident summary

[741123]

COMPLIANCE ORDER [CO#001] ADMINISTRATION OF DRUGS

NC#10 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 140 (2)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 140 (2) of O. Reg. 246/22

The licensee must comply with s. 140 (2) of O. Reg. 246/22

Further, the licensee shall:

1. Review and revise the home's process for the management of portable oxygen tank filling based on best practice and following consultation with the home's current oxygen provider. Document the date of this consultation, a description of the content reviewed and any changes that have been made to the home's process as a result.
2. Conduct and document audits by a registered staff twice a shift for one month to ensure that the resident's portable oxygen tank levels are within recommended fill levels during resident use. The audit should include any actions taken when the portable tank requires filling. The date and name of the person conducting each audit and a record of the audits are to be kept in the home.
3. Re-educate the registered staff member on the home's medical directives related to the treatment of nausea. The education must include at a minimum the assessment of a resident who is experiencing nausea and vomiting, and the documentation required. The education must be documented and include the date and the staff member who provided the education. A copy of the education is to be kept in the home.

Grounds

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to concerns about the administration of a resident's medication.

The resident had a specific medical diagnosis, and a MD ordered a specific medication.
A registered staff stated that the PSW who was responsible for the care of a specific resident using a portable oxygen tank was to ensure the tank was filled.

Progress notes documented that oxygen was not administered as prescribed to a resident when the portable oxygen tank was found empty by the Substitute Decision Maker (SDM) while visiting. The SDM reported the empty portable oxygen tank to the staff on the same date.

On another occasion the resident's progress notes documented that their portable oxygen tank was found empty by the SDM during a visit, and this was reported to the staff. Progress notes

documented that the resident's portable oxygen tank continued to need to be repaired and replaced.

The Acting DORC confirmed that the expectation of the home was to call the oxygen provider and obtain a functioning portable tank for a resident at the time the malfunction was noticed.

The home's failure to ensure that the resident received medication as directed by the prescriber led to the potential risk of an alteration in health status.

Sources:

Interview with registered staff and Acting DOC, Resident's Progress Notes, Physician Orders, Oxygen Saturation Summary, Oxygen Filled Record and Home's Oxygen Policy.

[#741750]

B) A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC), related to concerns about the administration of a resident's medication.

The home's policy titled "Medical Directive" date of origin: February 2022 Draft, stated the medical directive must be resident specific and may include but not limited to medications to treat conditions such as pain, fever, nausea, hypoglycemia, bowel care, skin care and possible UTI's. For nausea-Gravol (Dimenhydrinate) 25 milligrams (mg) per os (PO) every (q) eight hours as necessary (PRN) was prescribed by the physician for the resident under the home's medical directives.

Documentation indicated a resident experienced nausea, vomiting and required clear fluids. Progress notes documented the resident continued to experience nausea and vomiting and was transferred to hospital for assessment as requested by the substitute decision maker (SDM).

Registered staff confirmed that medication prescribed for nausea had not been administered to the resident during their shift, as the resident had only vomited once.

The Acting Director of Resident Care (Acting DORC) stated that the resident had not received a medication for nausea as per the Medical Directive and that they would have benefited from receiving the medication.

When the prescribed medication was not administered to the resident, it led to the actual risk of an alteration in health status and potential delay in further treatment.

Sources:

Interviews with Acting DORC, registered staff, review of the resident's clinical records, Medical Directive Policy-Draft, date of origin February 2022.

[706119]

This order must be complied with by November 4, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.