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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 31, 2024

Inspection Number: 2024-1181-0002

Inspection Type:
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Brierwood Gardens, Brantford

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2024.06.04 14:38:13 -04'00'

Additional Inspector(s)
Tatiana McNeill (733564)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 15-19, 22-24, 30, 2024 and May 1-3, 6, 2024
The inspection occurred offsite on the following dates: April 25, 30, 2024

The following intakes were inspected:

- Intake: #00108373 - CIS: 2678-000009-24 - Related to infection prevention and control
- Intake: #00108720 - CIS: 2678-000011-24 - Related to infection prevention and control
- Intake: #00109069 - CIS: 2678-000012-24 - Related to residents' rights
- Intake: #00110934 - CIS: 2678-000013-24 - Related to resident care and support services

- Intake: #00111418 - CIS: 2678-000015-24 - Related to resident care and support services

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

Resident Care and Support Services
Infection Prevention and Control
Residents' Rights and Choices
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Rights: Right to Quality Care and Self-Determination

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.
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:
19. Every resident has the right to,
ii. give or refuse consent to any treatment, care or services for which their consent is required by law and to be informed of the consequences of giving or refusing consent,

The licensee has failed to ensure that two resident's right to consent were

respected.

Rationale and Summary:
A staff member acknowledged that they obtained the personal health information of two residents for personal use, without first obtaining the consent of the residents.

The residents' right to consent were breached because of the staff members actions.

Sources: Homes investigation notes and interview with staff.

[741071]

WRITTEN NOTIFICATION: Residents' Bill of Rights: Right to Quality Care and Self-Determination

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the personal health information of two

residents, within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act.

Rationale and Summary:
A staff member acknowledged that they obtained the personal health information of two residents and shared the information of one of the residents on social media.

The personal health information of the residents was not protected when the staff member obtained their personal health information, and shared their information on social media.

Sources: The homes investigation notes, Code of Business Conduct (July 2023), and interviews with staff.

[741071]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that when a resident's plan of care was reassessed, that the outcomes of the reassessment were documented.

Rationale and Summary:

The resident was documented as having signs and symptoms of infection requiring additional precautions.

Additional precautions were removed despite the resident having recurrent signs and symptoms of infection.

The Infection Control Manager reported that when the resident had recurrent symptoms, that they consulted with the doctor and as it was highly unlikely that reinfection occurred, the resident was taken off the additional precautions. They acknowledged that this was not documented although it should have been.

By failing to document, the rationale for managing the resident's ongoing symptoms were not clear.

Sources: Resident's progress notes, line list and interview with the Infection Control Manager.

[741071]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was informed immediately of the suspicion and the information of the improper care of three residents that resulted in harm to the residents.

Rationale and Summary:
A. A Critical Incident System (CIS) was submitted to the Director related to a complaint that the home had received seven business days prior, alleging the improper care of two residents.

The Director of Care (DOC) acknowledged that the home did not report the incidents to the Director as required.

B. A CIS report was submitted to the Director related to the improper care of a resident that resulted in harm or a risk of harm to the resident.

The DOC acknowledged that they did not inform the Director immediately of the suspicion of improper care of the resident.

There was risk to the three residents when the home did not immediately inform the Director of the suspicion of improper care of the residents that resulted in harm to the residents.

Sources: Review of residents' clinical records, interviews with staff and the DOC.

[733564]

WRITTEN NOTIFICATION: Transferring and Positioning

Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary:
A CIS report was submitted to the Director related to the improper care of a resident that resulted in harm or a risk of harm to the resident.

The DOC acknowledged that the resident was improperly transferred which resulted in an injury to the resident.

The resident was injured as a result of the improper transfer.

Sources: Review of resident's clinical records, review of home's investigation notes, interview with staff and the DOC.

[733564]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the strategies to reduce and mitigate falls for a resident were in place at the time of their fall.

Rationale and Summary:
The resident's plan of care for falls related injury interventions were not in place when the resident fell.

The resident was not injured as a result of the fall, although not having the required falls strategies in place, may have contributed to the resident's fall and risk of a delayed response to the fall.

Sources: Resident's care plan, observations and interviews with staff.

[741071]

WRITTEN NOTIFICATION: Training and Orientation

NC #007 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 has failed to ensure that respiratory etiquette was included as part of the homes Infection Prevention and Control (IPAC) training.

Rationale and Summary:
The Infection Control Manager verified that the IPAC training used for all staff in the home did not include education on respiratory etiquette as required.

There was risk that staff were not knowledgeable about proper respiratory etiquette as it was not included in their IPAC training.

Sources: New Employee and Annual Education on Infection Prevention and Control Education, Mandatory Education Handbook (2024): Infection Prevention and Control and Interview with Infection Control Manager.

[741071]

COMPLIANCE ORDER CO #001 Plan of Care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

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

Specifically, the licensee shall:

1. Ensure falls interventions are in place for the identified resident as per their plan of care.
2. Complete weekly audits related to skin and wound interventions for the resident until the order is complied. Ensure documentation including the dates, times, and the outcome of the audits is kept on file.

Grounds:

The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in their plans.

Rationale and Summary:
A. A resident's care plan noted they required a specific intervention that was not used, and the resident sustained an injury as a result.

The DOC acknowledged that the resident should have had the intervention in place at the time of the injury.

The resident was injured related to their plan of care not being followed.

B. A resident's care plan noted they required the use of interventions that were not in place for the resident when they were left by staff for a period of several minutes.

There was risk to the resident because of being left for several minutes without the interventions in place as outlined in their plan of care.

Sources: Review of resident's clinical records, review of home's investigation notes, interviews with staff.

[733564]

This order must be complied with by June 21, 2024

COMPLIANCE ORDER CO #002 Directives by Minister

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

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

The licensee shall:

1. Educate all nursing staff on the specified testing requirements and related documentation requirements. Maintain a written record of the education provided, the staff members who completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

2. Complete daily audits to ensure that the specified testing, and results are documented accurately for the residents that meet the criteria for testing. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken as a result of the audits until this order is complied.
3. Ensure that the testing results are accurately communicated with public health. Maintain a written record of all communication with public health of the testing results including any resident refusals of testing until this order is complied.

Grounds:

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, that the Minister's Directive was complied with.

In accordance with section four of the Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022, to April 19, 2024) and the COVID-19 guidance document for long-term care homes in Ontario: Case and Outbreak Management, the licensee was required to ensure that the home followed the direction from their local public health unit for testing and isolation.

The licensee has failed to ensure that the home followed their local public health unit's requirements for testing and isolation.

Rationale and Summary:
As per the direction provided by public health, specific testing for a disease pathogen was to be completed for symptomatic residents. Residents were to

remain on additional precautions for this disease pathogen until the pathogen was ruled out.

Additional precautions were required for 10 days from symptom onset (five days after symptom onset, the resident could come out of isolation if symptoms had improved, and they could independently and consistently mask). Roommates would remain on additional precautions for the same period.

A resident developed signs and symptoms of infection and a test to rule out the specific disease pathogen was not completed. The resident was removed from additional precautions seven days later, after being asymptomatic for three days. The resident's roommate was asymptomatic and was also on additional precautions for the same period.

Two other residents developed symptoms of infection and a test to rule out the specific disease pathogen was not completed for either resident. Both residents remained on additional precautions until four days later.

A fourth resident developed signs and symptoms of infection and a test to rule out the specific disease pathogen was not completed. The resident remained on additional precautions until two days later.

The Public Health Inspector reported that if a resident did not have the test, the home would let them know by identifying this on the line list or through email. In a review of the communication between the home and the public health, there was no indication that this was completed. The Public Health Inspector reported that the four residents who did not receive the tests should have remained on additional precautions as outlined in the directions.

By not completing the testing as required, the disease pathogen was not ruled out for the four residents and the residents did not remain on additional precautions as required.

Sources: CIS: 2678-000009-24, CIS: 2678-000011-24, line list, emails, direction from public heath, resident record reviews, and interviews with the Public Health Inspector and Infection Control Manager.

[741071]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #003 Infection Prevention and Control Program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Complete one audit per day, which varies across shifts and resident home areas, to ensure that point of care personal protective equipment (PPE) supplies are available as required.
2. Complete twice weekly random audits, which vary across shifts and resident home areas, of three direct care staff members performing step one of the four moments of hand hygiene (before initial resident/resident environment contact).
3. Complete twice weekly audits of the High Touch Surfaces Logs for both the 300 and 400 home areas to ensure documentation is complete and the process is implemented as required.
4. Continue the audits until the order is compiled, maintaining a written record including the dates and times the audits were completed, the name(s) of the person(s) completing the audits, the results of the audits and any corrective action taken as a result of the audits.

Grounds:

The licensee has failed to ensure the implementation of any standard, or protocol issued by the Director with respect to infection prevention and control.

A. Section 5.6 of the IPAC Standard for Long-Term Care Homes (Revised September 2023), states that the licensee shall ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency. The licensee shall ensure that adequate personnel are available on each shift to complete required surface cleaning and disinfection.

The licensee has failed to ensure that high touch surfaces were cleaned as outlined in the homes policy Infection Control General Guidelines.

Rationale and Summary:
The home had two housekeeping shifts, 0730 to 1430h and 1300 to 1930h. The shifts were extended for one hour during outbreaks. The day shift cleaned the 300-home area, and the afternoon shift cleaned the 400-home area including an additional four specific rooms.

The homes Infection and Control General Guidelines policy, stated that Enhanced Daily Cleaning was used during an outbreak which included an additional precaution daily clean, followed by a clean and disinfection of high-touch surfaces in resident rooms and washrooms approximately 6-8 hours later and all high touch areas throughout the unit (inclusive of hallways, nursing stations/pod, soiled and clean utility rooms) were disinfected twice daily.

The home had a process in place in which the housekeeping staff documented the completion of high touch surfaces on High Touch Surfaces Logs, one for resident suites and one for public areas, for each of the two home areas.

During a whole home outbreak, there was no documentation to support that high touch surface cleaning and disinfection for residents' suites were completed for eight days on one home area and 14 days on the other home area. In addition, there was no documentation to support that public high touch surfaces were completed for either home area during this time.

Furthermore, when reviewing the documented times between the first and last suite high touch surface cleaning for one home area, it was noted that of the 15

documented times, 13 were documented as being completed between two and two and a half hours apart.

The Environmental Services Manager stated that with the allotted hours, there was not enough time in their shift for housekeeping staff to complete the required cleaning per policy.

Failing to complete the cleaning and disinfection as required puts the home at risk for increased disease transmission.

Sources: High Touch Surfaces Logs, Infection Control General Guidelines (ES H-05-05, revised February 1, 2022), and interview with the Environmental Services Manager.

[741071]

B. Section 6.1 of the IPAC Standard for Long-Term Care Homes (Revised September 2023), states the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

The licensee has failed to ensure that adequate PPE supplies were available and accessible to staff.

Rationale and Summary:

Inspector #741071 observed three staff members respond to a resident who had fallen. The resident was on additional precautions at the time of the fall. The three staff members did not have access to the required PPE at point of care and entered the room to assist the resident without the required PPE.

There was risk of potential disease transmission by not ensuring appropriate PPE was available to staff as required.

Sources: IPAC Standard for Long-Term Care Homes (Revised September 2023), observations and interviews with staff.

[741071]

C. Section 9.1 (b) of the IPAC Standard for Long-Term Care Homes (Revised September 2023), states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);

The licensee has failed to ensure that staff performed hand hygiene according to the four moments of hand hygiene.

Rationale and Summary:
Inspector #741071 observed a staff member enter a resident's room without performing hand hygiene. On a separate day, Inspector #741071 observed the same staff member and two additional staff members don PPE to enter the room of

another resident, who was on additional precautions, without performing hand hygiene.

The failure of staff to follow the four moments of hand hygiene, puts residents at risk for the transmission of disease-causing or infectious organisms.

Sources: Observations, IPAC Standard for Long-Term Care Homes (Revised September 2023), and interviews with staff.

[741071]

This order must be complied with by June 28, 2024

COMPLIANCE ORDER CO #004 Infection Prevention and Control Program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

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

The licensee shall:

1. Audit progress notes for residents symptomatic of infection to ensure that documentation of symptoms is completed each shift, maintaining a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) completing the audits, the results of the audits and any corrective action taken because of the audits until this order is complied.

Grounds:

The licensee has failed to ensure that symptoms of infection for two residents were documented every shift as required.

Rationale and Summary:
A resident developed signs and symptoms of infection which were resolved seven days later. During this time, there was a period of over 24 hours where there was no documentation in the progress notes related to symptom monitoring.

In addition, a second resident developed signs and symptoms of infection which were resolved after three days. There was no documentation in the progress notes related to infection monitoring during this time.

There was risk that the residents' symptoms were not managed as required because documentation was not completed.

Sources: Residents' progress notes, line list, and interview with the Infection Control Manager.

[741071]

This order must be complied with by July 12, 2024

COMPLIANCE ORDER CO #005 Infection Prevention and Control Program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 102 (11) (b) [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit, and implement a plan to ensure that hand hygiene, donning and doffing and high touch audits are completed during outbreaks as required.

The plan must include but is not limited to:

1. The necessary corrective actions, and the person(s) responsible for implementing them.
2. The type and frequency of quality monitoring, including who will be responsible and how it will be documented.

3. How the plan will be evaluated and reassessed for effectiveness, and the frequency of the evaluations.
4. Strategies to address non-compliance with the plan and who will be responsible for this.

Please submit the written plan for achieving compliance for inspection #2024-1181-0002 to Pauline Waldon (741071), LTC Homes Inspector, MLTC, by email to londondistrict.mltc@ontario.ca by June 14, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds:

The licensee failed to ensure that the home's outbreak management plan was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a written plan for responding to infectious disease outbreaks, and that it must be complied with.

Specifically, staff did not comply with the requirements of the home's LTC Auditing Frequency policy for outbreaks.

Rationale and Summary:
According to the homes policy, LTC Auditing Frequency, during an outbreak, four hand hygiene audits were required per resident home area declared in outbreak per shift, four donning and doffing audits were required per resident home area per shift

and environmental audits of high touch were to be performed three times per day distributed across all shifts.

Hand hygiene and donning and doffing audits were not completed as per the homes policy, and no high touch audits were completed, for an outbreak period in the home.

By not completing the audits as required during the outbreak period, there was risk that gaps in IPAC practices were not identified, therefore not addressed.

Sources: Hand Hygiene Audits, Donning and Doffing Audits, the homes LTC Auditing Frequency policy and interviews with the Infection Control Manager and Environmental Services Manager.

[741071]

This order must be complied with by June 28, 2024

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

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.