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: August 19, 2024
Inspection Number: 2024-1168-0003
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Elmwood Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22, 23, 25, 26, 29, 30, 31, 2024
The inspection occurred offsite on the following date(s): July 24, 25, 26, 2024
The following intake(s) were inspected:

- Intake: #00110470 - Critical Incident (CI) report related to falls prevention and management.
- Intake: #00116195 - Complaint related to medication management.
- Intake: #00117244 - Complaint related to alleged neglect of a resident.
- Intake: #00117328 - CI report related to a complaint response regarding alleged neglect of a resident.
- Intake: #00117352 - Complaint related to alleged neglect of a resident.
- Intake: #00119169 - Complaint related to medication management.
- Intake: #00121372 - Complaint related to alleged improper care of a resident.

The following intake was completed in this inspection:

- Intake: #00107404 - CI report related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that there was a written plan of care that set out the planned care related to required falls prevention interventions for a resident.

Rationale and Summary
Review of a resident's care plan did not show the resident required a specific falls intervention.

Personal Support Worker (PSW) #105 and Registered Practical Nurse (RPN) #107 stated that the resident required the specific falls intervention.

A follow-up review confirmed the home had made the change to include the use of the specific falls intervention in the resident's care plan.

Sources: Interviews with PSW #105 and RPN #107, review of the resident clinical records.

Date Remedy Implemented: July 26, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the resident no longer used a specific intervention.

Rationale and Summary
The resident's electronic Medication Administration Record (eMAR), care plan and

kardex all indicated to ensure that the resident had a specific intervention in place.

Personal Support Worker (PSW) #104 observed the resident with Inspector #522 and noted the resident did not have the specific intervention in place.

Registered Nurse (RN) #110 and RN #106 both stated that the resident no longer required the intervention. RN #104 and RN #106 stated the resident's care plan should have been updated and the use of the intervention was removed from the resident's plan of care.

There was no risk to the resident as the resident no longer used the intervention.

Sources: Observations of the resident; review of the resident's clinical records and interviews with PSW #104, RN #110 and RN #106.

Date Remedy Implemented: July 30, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care provided clear direction to staff.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care regarding alleged

neglect of a resident. The complainant was concerned that the resident exhibited a specific behaviour and staff were not doing anything about it.

There were no interventions in the resident's care plan and kardex related to the specific behaviour.

Registered Nurse (RN) #106 stated that the resident did exhibit the behaviour and staff were to follow specific interventions. RN #106 acknowledged that the resident's care plan did not indicate that the resident exhibited the specific behaviour and interventions.

The resident's care plan was updated with the specific behaviour and interventions.

Sources: Review of a complaint intake, the resident's clinical record and interviews with RN #106 and other staff.

Date Remedy Implemented: July 30, 2024

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident;

The licensee has failed to ensure that clear directions related to the administration

of a medication was given to staff and others who provided direct care to a resident.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to a resident who did not receive a medication for a specific timeframe. The complainant stated the resident had sustained an overall decline due to an abrupt discontinuation of the medication.

The resident's medication orders did not include clear direction to staff and those administering the medication.

Progress notes documented by a physician, indicated that the medication should have had specific direction.

Pharmacy Team Lead #118 acknowledged a medication assessment of the resident should have occurred.

The resident's physician confirmed the medication did not have clear directions for administration and that this put the resident at risk of specific symptoms.

The home's failure to ensure that the resident had the required assessment related to a medication placed the resident at risk for not receiving medications as prescribed.

Sources: Review of complaint Intake, the resident's progress notes, assessments, Point Click Care, medication orders; and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Plan of care

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

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care which alleged that a resident did not receive proper care.

Over the course of two days, documentation indicated that a resident had a worsening of symptoms. There was no documentation that the resident's physician was notified of the resident's change in condition.

Two days after the resident had developed a worsening of symptoms, The resident's physician noted during rounds that the resident had gotten worse and the resident was sent for medical treatment.

The resident's physician stated they would have expected staff to notify them when staff noted the resident had a worsening of symptoms, instead of waiting until they came on site.

Sources: Review of complaint intake, the resident's clinical records; and interviews with the resident's physician and other staff

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development of the resident's plan of care related to a change in one of the resident's medications.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care (MLTC) that a resident had been prescribed a change in medication in 2023, and the SDM had not been informed of the change. The SDM indicated that they were not made aware of the medication change until 2024, when they had requested and reviewed the resident's medication list.

The resident's record review indicated that the home's physician had changed the dosage of the medication in 2023. The resident's progress notes, and the medication order were reviewed and there was no documentation that resident's SDM was informed of the medication change.

The Director of Care confirmed the home's expectation was to inform the SDM if there were any changes to a resident's medication.

The physician stated that the medication change was not discussed with the resident's SDM.

When the licensee failed to inform the resident's SDM, the resident's SDM was not allowed to participate fully in the development and implementation of the resident's plan of care.

Sources: Review of complaint intake, e-mail correspondence, the resident's progress notes and medication orders; and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a resident's intervention was applied as ordered.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care with concerns that a resident did not receive proper care.

The resident's care plan and kardex indicated that the resident required a specific intervention.

The resident was observed sitting with Personal Support Worker (PSW) #114. The resident did not have the intervention in place. PSW #114 stated the resident did not require the intervention.

Registered Practical Nurse (RPN) #107 stated the resident required the intervention at all times and asked PSW #114 to ensure the intervention was in place.

There was risk to the resident by not ensuring the intervention was in place.

Sources: Observations of the resident; review of complaint intake, the resident's clinical record; and interviews with PSW #114, RPN #107 and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that reapproaches to provide care to a resident were documented.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care that a resident was not receiving personal care.

The resident's care plan indicated that the resident would occasionally decline care and staff were to re-approach the resident.

Point of Care (POC) documentation noted the resident had refused care. There was no documentation that staff reapproached the resident or that care was offered on a different day or shift.

On another date, there was no documentation in POC that the resident received care, or further documentation that care was offered on a different day or shift.

On both dates, there was no documentation in the resident's progress notes that the resident refused care and that the resident was reapproached.

Personal Support Worker (PSW) #104, PSW #111 and PSW #112 all stated that the resident often refused care and the resident needed to be reapproached for care.

Registered Nurse (RN) #106 stated the resident often refused care. RN #106 stated refusals should be documented in the resident's progress notes as they reviewed the progress notes to see if the resident refused care.

The Director of Care (DOC) stated if the resident refused care staff should reapproach the resident or offer care on a different day or shift. This should be reported to the registered staff and a progress note should be entered related to the refusal and the attempts made to reapproach the resident.

Staff did not document reapproaches to care, therefore there was no clear record of which interventions were effective for the resident, how often the resident refused care, and how many times staff needed to reapproach the resident to provide care.

Sources: Review of complaint intake, the resident's clinical records; and interviews with PSW #104, PSW #111, PSW #112, RN #106, the DOC and other staff.

WRITTEN NOTIFICATION: Complaints Procedure — Licensee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (b)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and

The licensee has failed to ensure their written complaints procedures included information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry.

The home's "Complaint Management" policy did not include information about how to make a complaint to the patient's ombudsman or the Ministry of Long-Term Care.

The Director of Care (DOC) acknowledged the home's complaints policy did not include the required information and would inform Corporate.

Sources: Review of a Critical Incident report, the home's "Complaint Management" policy ADMIN 3-010.01 with a review date of March 31, 2024; and interview with the DOC.

WRITTEN NOTIFICATION: General Requirements

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to include the implementation dates associated with the 2023 improvements on their 2024 Annual Falls Prevention Program Evaluation.

Rationale and Summary
Review of the Annual Program Evaluation for the Fall Prevention and Injury Reduction Program showed no associated implementation dates with the 2023 improvements.

The Director of Care (DOC) acknowledged that the implementation dates were not documented on the 2024 Annual Program Evaluation for the Fall Prevention and Injury Reduction Program.

The home's failure to ensure the annual evaluation of their falls prevention program included implementation dates for the previous year's changes impacted the home's ability to assess the effectiveness of those changes which may negatively

affect the quality of life of the resident's involved in the program.

Sources: Review of the Annual Program Evaluation for the Fall Prevention and Injury Reduction Program dated May 2024, review of the home's "Annual Program Evaluation" policy #ADMIN7-010.04 reviewed March 31, 2024; and an interview with the DOC.

WRITTEN NOTIFICATION: Required Programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's Falls Prevention and Injury Reduction program related to Falls assessments.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure that they were complied with.

Specifically, registered staff did not comply with the licensee's requirement to complete a Post-Fall huddle as well as a Fall Risk Screen and Fall Risk assessment for a resident, as required.

Rationale and Summary

A) Review of the home's "Fall Prevention and Injury Reduction" policy stated that "A Fall Risk Screen is completed by a regulated health professional within 24-hours to determine any change in resident's risk for a fall AND risk of a fall-related injury and "If any of the following indicators (A score of 16 or more on the Fall Risk Screening, Immediate Risk with Significant Risk Factors, Immediate Risk for Fall-related Injury) are present on the Fall Risk Screen a Fall Risk Assessment is completed by a regulated health professional within 72-hours to determine resident specific risk and action accordingly"

A resident's clinical records indicated that they had a fall and required treatment. The resident's clinical assessments in Point Click Care (PCC) showed no Fall Risk Screen or Fall Risk Assessment were completed, as required.

The Director of Care (DOC) stated that it was the expectation of the home to complete a Fall Risk Screen and Fall Risk Assessment, as required. The DOC acknowledged that the resident required a Fall Risk Screen and Fall Risk Assessment and they were not completed as per protocol of the home.

B) Review of the home's "Fall Prevention and Injury Reduction-Post-Fall Management" policy stated that "An Interdisciplinary Team huddle is conducted on the same shift that the fall occurred. Follow the Post-Fall Huddle Questions to collect the information needed to conduct a root cause analysis of the fall"

The resident's progress notes indicated "Post-Fall Huddle completed: no"

Registered Practical Nurse (RPN) #107 stated that the post-fall huddle documentation was filed in the resident's paper chart. RPN #107 was unable to locate the resident's Post-Fall Huddle documentation in the resident's paper chart.

The home's failure to complete the resident's Post-Fall huddle, Fall Risk Screen, and Fall Risk Assessment to identify potential strategies to prevent future falls placed the resident at risk and may have impacted their quality of life.

Sources: Review of the resident's clinical records, review of the home's "Falls Prevention and Injury Reduction" policies CARES-O10.02, reviewed March 31, 2024, and "Post-Fall Management" policy CARES-O10.05, reviewed March 31, 2024; and interviews with RPN #107 and the DOC.

WRITTEN NOTIFICATION: Pain Management

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care which alleged that a resident did not receive proper care.

A resident had received pain medication on several occasions which was noted as ineffective. When the resident's pain was not relieved by initial interventions, the

resident did not have a pain assessment completed.

Registered Nurse (RN) #106 who was the Pain Lead, stated the resident should have had a pain assessment completed.

Sources: Review of a complaint intake, the resident's clinical records, the home's "Pain Management and Assessment" policy CARE8-010.01 revised March 31, 2024; and interviews with RN #106 and other staff.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that a written response to a person who made a complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A complaint was received by the home regarding a resident's care. The home had

investigated the complaint and the Director of Care (DOC) sent a written response to the complainant.

The written response did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

The DOC stated they were not aware of the requirement to include the the Ministry's telephone number, hours of service and contact information for the patient ombudsman.

Sources: Review of a Critical Incident report, the home's complaints binder and interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall,
A) Review and revise a resident's plan of care to include the interventions, as

assessed.
B) Educate all registered nursing staff on a specific home area on a specific resident assessment.
C) Reeducate all registered nursing staff on a specific home area on processing physician's orders.
D) A record will be kept of the education content, the names of the staff who completed the education and the dates upon which the education was completed.

Grounds
The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care which alleged that a resident did not receive proper care.

A) The resident had a change in condition.

i) The resident's physician gave specific verbal orders related to the resident's change in condition. There was no physician's verbal order written regarding the resident's change in condition.

On two separate dates, different staff members had documented concerns related to the resident's change in condition.

It was not until seven days after the resident's change in condition that a focus was initiated in the resident's care plan related to the physician's order.

The Physician stated staff should have written a verbal order for the resident when

they had given the order.

ii) On another occasion, the resident was seen by a physician and an order was received related an intervention for the resident's change in condition. The resident's care plan did not indicate the intervention as ordered.

The Director of Care (DOC) stated a physician's order should be included in the plan of care.

B) The resident's electronic Treatment Administration Record (eTAR) noted registered staff were to monitor the resident after their change in condition.

The home's "Post Fall Clinical Pathway" CARE5-O10.05-T1 noted post fall, registered staff were to monitor a resident for specific changes which was not included in the resident's eTAR. The resident was also seen by a physician and an order was received for specific interventions for the resident.

There was no task in the resident's plan of care related to specific monitoring of the resident, as required.

A focus was initiated in the resident's care plan eight days after the resident was seen by the physician. The care plan only indicated one of the interventions that were ordered.

Registered Practical Nurse (RPN) #107, Registered Nurse (RN) #116 and RN #106 all stated that specific monitoring should have been completed for the resident when they had a change in condition. RN #106 stated the monitoring should be documented in a progress note.

The resident's physician stated they would have expected registered staff to monitor the resident when they had a change in condition.

The DOC stated registered staff should monitor a resident who has a change in condition. The DOC stated this should be included in the resident's care plan but not necessarily in the eTAR.

Staff not reviewing and revising the resident's plan of care when they had a change in condition, put the resident at risk for complications.

Sources: Review of a complaint, the resident's clinical records, the home's "Post Fall Clinical Pathway" CARE5-O10.05-T1, Medisystem Policies and Procedures 16.4.2; and interviews with RPN #107, RN #116, RN #106, the resident's physician, and the DOC. [522]

This order must be complied with by October 4, 2024

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

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.