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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 18, 2024	
Original Report Issue Date: December 7, 2023	
Inspection Number: 2023-1097-0003 (A1)	
Inspection Type: Proactive Compliance Inspection	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell White Eagle Long Term Care Residence, Toronto	
Amended By Kehinde Sangill (741670)	**Inspector who Amended Digital Signature** Kehinde Sangill

AMENDED INSPECTION SUMMARY

This report has been amended to: extend the compliance due date

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Lead Inspector Kehinde Sangill (741670)	**Additional Inspector(s)** Oraldeen Brown (698)
Amended By Kehinde Sangill (741670)	**Inspector who Amended Digital Signature** Kehinde Sangill Digitally signed by Kehinde Sangill Date: 2024.01.19 14:51:50 -05'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023, and November 1-3, 6-10, 14, 15, 2023.
The inspection occurred offsite on the following date(s): November 8, 16, 2023.

The following intake(s) were inspected:

- Intake: #00100623 - Proactive Compliance Inspection

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

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

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (iv)
Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(iv) that complies with manufacturer's instructions for the storage of the drugs; and

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that complied with manufacturer's instructions for the storage of the drugs.

Rationale and Summary

During observation of the medication room, one sealed expired medication was discovered. The medication had an expiry date of July 2023. The expired medication was immediately removed when brought to the home's attention.

The home completed monthly audits however, this medication was missed during the last audit.

A Registered Nurse (RN) and the Director of Care (DOC) both acknowledged that the identified government stock medication had expired and should have been identified during their monthly audits.

There was low risk as the medication did not reach the residents.

Sources: Pharmacy and Therapeutics policy #LTC-CA-WQ-200-06-16 last revised June 2020, observation of medication room government stock drugs, interview with RN and other relevant staff.
[698]

Date Remedy Implemented: November 6, 2023

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the

following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under s. 82 (7) of the Act.

Rationale and Summary

O. Reg 246/22, s. 261. (1) 4. indicated that pain management training for all staff who provided direct care to residents, was to be provided.

Documentation provided by the home indicated that one RN, one Activity Aide (AA) and two Personal Support Workers (PSWs) had not completed the annual pain management training in 2022. These trainings were never completed at the time of this inspection.

The DOC and Pain lead both acknowledged that annual training in pain management was not completed by the four staff members.

Failure to train staff in pain management on an annual basis, increased the risk of residents not having their pain recognized and managed.

There was low risk when the home failed to provide pain management training to staff.

Sources: Review of Surge annual pain management training for 2022, interviews with the DOC and other relevant staff.
[698]

WRITTEN NOTIFICATION: Additional Training — Direct Care Staff

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under s. 82 (7) of the Act.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 260 (1), the home was required to provide all direct care staff annual training in skin and wound care.

The home's Surge training report from January 1, 2022, to December 31, 2022, showed that a PSW did not complete training on skin care and pressure ulcer for direct care staff.

The DOC verified that the PSW did not compete the skin and wound care training in 2022 and acknowledged the training should have been completed.

Failure to provide training on skin care and pressure ulcer to direct care staff may compromise staff's ability to follow proper protocol when they identify residents with skin impairment.

Sources: Review of Surge learning course completion record: Skin Care and Pressure Ulcers for Direct Care Staff, January 1, 2022, to December 31, 2022; and interview with DOC.
[741670]

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)

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 the written plan of care for a resident set out clear directions to staff and others who provided direct care related to dietary intervention.

Rationale and Summary

A resident's care plan indicated they required a specific dietary intervention related to their health condition. Staff were observed providing the resident with food item that was not compatible with the dietary intervention. Staff were required to verify individualized dietary interventions for all residents in the diet list at point of meal service. The food item was not included in the diet list as one of the foods the resident should avoid.

A PSW acknowledged that they were not aware the food item was to be avoided because it was not listed in the diet list.

The Food and Nutrition Manager (FNM) stated that staff ought to have known that all products of one of the food items listed in the diet book should be avoided.

A Registered Dietitian (RD) #125 stated that staff were required to follow the diet list for each resident, and that the communication was unclear to staff given the discrepancy between the diet list and the care plan.

Failure to provide clear direction to direct care staff resulted in the resident receiving food that was not consistent with their nutritional plan of care.

Sources: Observations; resident's clinical records; interviews with FNM, PSW, and RD #125.
[741670]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Duty of licensee to comply with plan
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 the care set out in residents' plan of care were provided as specified in the plan.

Rationale and Summary

a) A resident's care plan indicated that they required a specific eating device. The resident was observed eating without the specified device.

A Dietary Aide (DA) and PSW indicated they were unaware the resident required the eating device. The PSW acknowledged that the eating device should have been provided as specified in the resident's care plan.

The FNM acknowledged that the diet list was not updated to include the device as specified by the resident's care plan.

Failure to provide eating aid as specified in the resident's plan of care may impact the resident's ability to eat independently.

Sources: Observations; resident's care plan; and interviews with DA, PSW, FNM and other staff.
[741670]

Rationale and Summary

b) A resident required assistance with application of treatment devices daily. The resident was observed not wearing the treatment devices.

The resident indicated that the treatment devices have been missing for about two months.

A PSW verified that the resident was not wearing the treatment devices as specified in their plan of care because they were missing.

Failure to provide the care set out in the plan of care for the resident may impact the resident's health.

Sources: Observations; review of resident's clinical records; interviews with resident and PSW.
[741670]

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.
Additional training — direct care staff
s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.

The licensee has failed to ensure that a PSW, who provided direct care to residents, as a condition of continued contact with residents, received training in abuse recognition and prevention.

Rationale and Summary

Pursuant to Ontario Regulation (O. Reg). 246/22 s. 260 (1), the home was required to provide all direct care staff with annual training in recognition and prevention of abuse.

The home's Surge training report on abuse prevention from January 1, 2022, to December 31, 2022, showed that a PSW did not complete the training on abuse prevention.

The DOC verified that the PSW did not complete the abuse training in 2022, and acknowledged the training should have been completed.

Failure to provide training on abuse prevention to front line staff may impede their ability to recognize and address abuse of residents.

Sources: Review of Surge learning course completion record: Abuse Prevention series, January 1, 2022, to December 31, 2022; and interview with DOC.
[741670]

WRITTEN NOTIFICATION: Directives by Minister

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Binding on licensees
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 Licensee has failed ensure that a policy directive that applied to the long-term care home, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirement set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed.

The document required that masks were worn indoors in all resident home areas.

Rationale and Summary

On November 10, 2023, a PSW was observed not wearing a surgical mask in the home.

The PSW stated that they forgot to wear a surgical mask upon entering the home. They acknowledged that they did not wear a mask while on the resident home area (RHA).

The Infection Prevention and Control (IPAC) lead noted that staff were required to wear mask upon entering the home based on the home's IPAC protocol.

A home's memo dated November 3, 2023, advised staff that mandatory masking would be in effect throughout the entire home starting November 7, 2023. According to the memo, all staff, students, and volunteers would be required to wear a surgical mask at all times, with the exception of when eating or drinking in designated staff break areas.

Staff's failure to don a surgical mask in the RHA increased the risk of transmission of infection to residents and other staff.

Sources: Observations; Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, COVID-19 Guidance Document for Long-Term Care Homes in

Ontario updated November 7, 2023; interviews with PSW and IPAC lead.
[741670]

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 37 (1)

s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

Rationale and Summary

A resident's care plan indicated they received showers in the evening on their bath days and required assistance of one staff with bathing activities.

The resident indicated that they did not receive a shower on their scheduled bath days in the previous two weeks.

A PSW verified that the resident missed a shower day one week in the previous month. The PSW acknowledged that the resident was not given the option of making up the missed shower day. As a result, the resident received one shower during that week.

The DOC acknowledged that showers should be provided twice a week for residents as per their schedule. They noted that the resident should have been offered the option of making up their missed shower the next day or the following shift.

Staff's failure to provide shower to the resident twice a week may negatively impact their hygiene.

Sources: Resident's clinical records, residents' bath schedule; interview with resident, PSW and DOC.

WRITTEN NOTIFICATION: Foot Care and Nail Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee has failed to ensure that a resident received fingernail care, including the cutting of fingernails.

Rationale and Summary

The resident's care plan required that PSW provide fingernail care routine on shower days and as required. The resident's fingernails were observed showing significantly past the end of each finger on both hands.

The resident indicated that their fingernails had not been cut in two weeks.

A PSW verified that the resident's fingernails were long and should have been cut.

Two PSWs acknowledged they did not cut the resident's nails when they assisted them with showers the previous two weeks.

The DOC acknowledged that staff should have checked the resident's fingernails on their shower days and cut them if they were long.

Failure to cut the resident's fingernails put them at risk of unintentional injury from long fingernails.

Sources: Observations; review of resident's clinical records; interviews with the resident, PSW, and DOC.
[741670]

WRITTEN NOTIFICATION: Dress

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that a resident was dressed in their own clean clothing.

Rationale and Summary

A resident was observed wearing visibly soiled clothing. An hour and a half later, the resident participated in activities wearing the same soiled clothing.

A PSW verified that the resident was sent for activities wearing soiled clothing. The PSW acknowledged that the resident's clothing should have been cleaned or changed immediately after the meal, but they did not notice the resident's clothing was dirty at the time.

Failure to ensure the resident wore clean clothing could negatively impact their self-esteem.

Sources: Observations; interviews with resident and PSW.
[741670]

WRITTEN NOTIFICATION: Food Production

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and

The licensee has failed to ensure that milk served to residents, was stored to preserve taste, nutritive value, appearance, and food quality.

Rationale and summary

Two containers of milk served with lunch were observed not being stored in a manner, to preserve food taste and quality. The containers of milk along with other beverages were left in a container without ice for approximately 30 minutes prior to it being served to the residents. The temperature reading at the time of service was approximately 18 degrees Celsius, verified by the cook.

The DA stated that they forgot to put the milk on ice before delivering to the unit. They noted that milk was usually served directly from the fridge. However, the elevator was broken, and the milk had to be transported and kept on the unit prior to being served.

According to the home's food temperature log document, cold foods must have a temperature reading of less than four degrees Celsius at point of service.

Failure to serve residents milk at the required temperature increased the risk of spoilage and may negatively impact the taste.

Sources: Observations; home's food temperature log; and interviews with the DA and cook.
[741670]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to comply with their food temperature control policy for recommended food temperature monitoring at point of service.

In accordance with O. Reg 246/22, s. 11. (1) (b) the food service team members were required to take and record food temperatures once food has been placed in the hot steam table, on the food temperature sheet.

Rationale and Summary

Specifically, staff did not comply with the home's food temperature policy that required food service team members to check and record the food temperature before meal service.

Food temperature logbook showed missing food temperatures for the following meals:

- Breakfast: three days in September and five days in October 2023.

- Lunch: 20 days in September and 16 days in October 2023.

- Supper: 14 days in September and 18 days in October 2023.

The FNM verified that food temperatures were not taken and recorded as per policy. The FNM noted that they were aware food temperatures were not being taken and recorded and that staff education had been provided.

Failure to take and record food temperature before meal service posed the risk of food being served to residents at unsafe and unpalatable temperature.

Sources: Review of the food temperature logs for September and October 2023, and the home's Food temperature policy; interview with FNM and other relevant staff.
[741670]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to IPAC.

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program. Specifically, cleaning of shared equipment as required by Routine Practices and Additional Precautions 9.1 (e)(i) under the IPAC Standard.

Summary and Rationale

a) The Inspector observed three staff members using shared equipment in a resident's room. The staff members used a device during the care of a resident. The device was not disinfected after use.

The inspector verified with a PSW, who acknowledged that they used a towel and water to clean the device after using it with a resident.

A staff member confirmed that they did not use disinfectant wipes provided by the home to clean the device prior to returning it to its storage area.

Staff failure to disinfect shared equipment, put residents at risk of infection.

Sources: observations; resident's electronic health records, policy #LTC-CA-WQ-205-02-01 last revised January 2023, interview with PSW and other relevant staff.

[698]

The home has failed to ensure that Routine Practices were in accordance with the "IPAC Standard for Long-Term Care Homes April 2022". Specifically, hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC standard.

Rationale and Summary

b) A Laundry Aide (LA) was observed wearing disposable gloves and pulling a cart of dirty laundry down the hallway of a RHA. The LA pulled the cart to the elevator and entered the code into the keypad while wearing the same disposable gloves.

The LA acknowledged they used the same disposable gloves to handle dirty laundry and touch the keypad. They noted they were aware they should have removed the gloves and performed hand hygiene before touching the keypad but failed to do so.

The IPAC lead noted that staff should have removed their disposable gloves as soon as they completed their task and performed hand hygiene before interacting with the environment.

Staff's failure to follow proper hand hygiene practice before touching the elevator keypad increased the risk of spreading infections in the home.

Sources: Observations; interviews with LA, IPAC lead and other relevant staff. [741670]

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 (4) (a)
Integration of assessments, 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; and

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

The Licensee shall ensure that:

1) A RD, and a Speech Language Pathologist (SLP) if indicated, complete a swallow assessment for a resident. The assessment shall include reassessment of adaptive aids for meals, fluid consistency and safe feeding techniques;

2) Based on the swallow assessment, revise the resident's plan of care to include safe feeding technique that sets out clear directions to staff on how to safely feed the resident and actions required if the resident coughs during meals;

3) Train Registered Practical Nurse (RPN) #132 and all the staff who feed the resident on the above-mentioned safe feeding techniques;

4) Maintain a record of the training provided, including the date, who conducted the training, and names of staff who attended the training;

5) Conduct audits of staff feeding of the resident using the above-mentioned safe feeding techniques for a period of three weeks following the service of this order. The audits shall include breakfast, lunch, supper and snacks;

6) Maintain a record of the audits, including the date, who conducted the audits, staff audited, results of each audit and actions taken in response to the audit findings.

Grounds

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

Rationale and Summary

The resident was at risk of choking related to their health condition. The plan of care required that fluids were offered by a specific adaptive aid or a spoon.

The resident was observed drinking fluid from the adaptive aid and repeatedly throat clearing, while the RPN held the adaptive aid continuously to the resident's mouth for approximately one minute. The RPN removed the device from the resident's mouth after the inspector intervened. Shortly thereafter, the resident

coughed. The RPN resumed feeding the resident fluid from the adaptive aid immediately after the resident stopped coughing.

The following day, a PSW was observed feeding the resident. The PSW gave the resident fluid from the adaptive aid, and the resident was observed clearing their throat after taking a sip. The PSW stopped feeding fluids to the resident with the adaptive aid and used a spoon.

Four days later, a RN was observed feeding the resident fluids with a spoon, no throat clearing or coughing was noted.

The RPN verified that the resident was at risk of choking and was coughing after drinking from the adaptive aid. The RPN stated it was okay for the resident to drink continuously from the adaptive aid as long as they swallowed and were not coughing while drinking. The RPN indicated that the resident often coughed with meals, and they usually resumed feeding the resident when they stopped coughing. They acknowledged that a referral was not sent to the RD because coughing with meals was expected with the resident's health condition.

The PSW stated that the resident often coughed when drinking from the adaptive aid, particularly if fed continuously without frequent breaks. The PSW indicated they adjusted their feeding technique from observing the resident cough when drinking with the adaptive aid.

The RN indicated that they fed the resident's fluid with a spoon because the resident's swallowing was delayed, and they determined that feeding with the adaptive aid was not safe. They stated that the resident would benefit from reassessment by a RD and that a referral should have been sent when the resident was coughing during meals. The RN acknowledged that the care plan should be updated and revised to provide clear directions to staff on how to safely feed the resident.

Both the RPN and RN indicated that the resident had experienced functional decline since admission into the home.

RD #125 and #133 indicated that a RD referral should be sent when a resident experienced functional decline and if there were any issues with diet texture tolerance and use of adaptive aids.

RD #133 stated that a swallow assessment to rule out the risk of aspiration should have been completed for the resident when coughing during meals was observed. They noted that it was not appropriate for staff to determine if coughing with meals was normal for the resident. They also noted that staff should not try different approaches to see what works with managing the resident's health condition. Rather, they should have referred the resident to the RD for reassessment and to determine if a SLP consultation was appropriate.

Staff's failure to collaborate with the RD in the management of a resident's health condition put them at risk of aspiration and aspiration pneumonia.

Sources: Mealtime observations; resident's clinical records; interviews with PSW, RPN, RN, RD #125, RD #133 and other staff.
[741670]

This order must be complied with by February 23, 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.