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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 18, 2024

Inspection Number: 2024-1463-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Mill Creek Care Centre

Long Term Care Home and City: Mill Creek Care Centre, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 23-26, 2024 and October 1-4 and October 7, 2024
The inspection occurred offsite on the following dates: September 25-27, 2024 and October 1-4 and October 7, 2024

The following intake(s) were inspected:

- Intake: #00115055 related to improper/incompetent care of a resident.
- Intake: #00118828 related to a medication incident/adverse drug reaction.
- Intake: #00121196/Follow-up: Compliance Order #001 from inspection #2024-1463-0002 regarding FLTCA, 2021 s. 24 (1) - Duty to protect.
- Intake: #00121760/Follow-up: Compliance Order related to O. Reg. 246/22 s. 23.1 (3) - Air conditioning requirements.
- Intake: #00123686 - A complaint related to the dietary program in the home.
- Intake: #00126879 related to a COVID-19 outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1463-0002 related to FLTCA, 2021, s. 24 (1)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2024-1463-0003 related to O. Reg. 246/22, s. 23.1 (3)

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

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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; and

The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident related to their heat risk status.

Rationale and Summary
There were three residents who had heat-related illness (HRI) assessments completed that identified a different risk level than their plan of care.

The directions to staff were not clear if they were to review multiple sources of information regarding the resident's status related to heat risk. Registered staff conducting the heat risk assessments made a series of errors when completing the documentation required of them. The plans of care were also not verified to ensure that the information was accurately transcribed.

Sources: Interviews with registered staff, Director of Care (DOC), Executive Director (ED); review of resident heat risk assessments and plans of care.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 the care set out in the plan of care was provided to the resident as specified in the plan.

1. Rationale and Summary
A resident's plan of care stated that they were to get a specific drink at lunch.

During three separate observations, that resident was not provided with their

preferred drink at lunch.

The Food Service Manager (FSM) said that they had the specified drink available and that the specified drink should have been provided at lunch.

Sources: The resident's clinical record, a copy of stickers for resident labelled dietary items; observations of lunch; and interviews with the resident and Food Service Manager (FSM).

2. Rationale and Summary
A resident's plan of care stated that they were to get a specific drink at lunch.

During three separate observations, that resident was not provided with their preferred drink at lunch.

The Food Service Manager (FSM) said that they had the specified drink available and that the specified drink should have been provided at lunch.

Sources: The resident's clinical record, a copy of stickers for resident labelled dietary items; observations of lunch; and interviews with the Food Service Manager (FSM).

3. Rationale and Summary
A resident's plan of care for toileting was not followed as per their plan of care.

As a result, the resident was at risk of injuries.

Sources: Interviews with a Personal Support Worker (PSW), a Resource Nurse, and the Director of Care (DOC); record reviews of resident's care plan and the Critical Incident (CI) report.

WRITTEN NOTIFICATION: Conditions of licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the conditions of Compliance Order (CO) #001 from inspection #2024-1463-0003 served on July 18, 2024 with a compliance due date of August 12, 2024.

The licensee did not ensure that air conditioning was operating in resident rooms when needed to maintain the temperature at a comfortable level for residents between May 15 and September 15 or when the use of air conditioning had been identified in order to protect residents from heat related illness in the heat related illness prevention and management plan.

Rationale and Summary

1. The licensee did not include what actions or strategies (which includes supplemental air conditioning units) were implemented by staff to ensure that resident room temperatures were maintained at a comfortable level for residents. The plan of care for residents whose rooms were documented to be over 26 degree Celsius (C) in August and September 2024 by staff did not have any documentation related to the resident's comfort, the temperature of their room, what interventions were implemented and the follow up to the intervention(s).
2. A total of seven portable air conditioning units were made available to staff to promote timely installation where and when necessary, with the permission of residents and/or their substitute decision maker. However, no records were maintained as to who was offered an air conditioner, who refused an air conditioner and the time and date as to whether any were installed or

uninstalled. The progress notes and care plans for six residents who complained to the inspector or who had rooms recorded to be 26C or higher in July, August or September did not have any information regarding heat or heat alleviating interventions.

3. The licensee did not ensure that registered staff documented in the resident's plan of care as to who received or required a portable air conditioning unit and for what particular reason.

Sources: CO #001 from inspection #2024-1463-0003, observations of air and humidity values via thermometers, general tour of the building, reviewed progress notes, heat risk assessments, plan of care for multiple residents, emails from the Executive Director (ED) to staff, staff education sign-in sheets completed in August 2024 and interviews with multiple residents, registered practical nurses (RPN), random Personal Support Workers (PSW), Executive Director and Responsive Management nursing consultant.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
Compliance Order (CO) #001 from inspection #2024-1463-0003 related to air conditioning requirements under s. 23.1 (3) was served on July 18, 2024 with a compliance due date of August 12, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 11.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.

The licensee has failed to ensure that the plan of care for some residents included protective measures required to prevent or mitigate heat-related illness (HRI). Protective measures include but are not limited to the use of cooling equipment.

Rationale and Summary
The home's cooling system for resident rooms over the summer of 2024 was not effective in keeping some resident rooms below 26 degrees Celsius (C) when

outdoor temperatures reached or exceeded 26 degrees Celsius. The conditions thereby increased the risk for residents to experience heat-related illness and discomfort.

The plans of care for multiple residents which were assessed as either high, moderate, or low risk for HRI, included identical interventions, despite each resident having different personal comfort levels, risk factors related to their clinical profile, and exposure to different environmental conditions in their rooms. A resident who was assessed as high risk for HRI, had an oxygen concentrator in their room, which contributed extra heat to the room. A resident who was assessed as moderate risk for HRI was in an area of the home that was subjected to more direct sun and heat. A resident was assessed as low risk for HRI, but had complained to staff that they were always feeling uncomfortable despite their room temperature being recorded below 26 degrees Celsius. These profiles were not captured in their plans of care, followed by individualized interventions.

Interventions in the plans of care for all three residents included mitigating strategies such as “monitor or observe for heat-related symptoms; suitable light weight clothing; encourage or push fluids, and close window and drapes”. These strategies may or may not prevent HRI and are not considered protective measures that air conditioning equipment can provide.

The plans of care were not individualized to ensure that the interventions to address resident discomfort were appropriate and applicable to each resident, which includes decisions regarding each resident's room environment.

Failure to assess the resident's environment in addition to clinical risk factors and to subsequently include the protective measures in the plan of care for staff awareness and implementation may increase the resident's risk to heat-related illness.

Sources: Observations of resident rooms; review of heat risk assessments and plans of care; and interviews with registered staff, Director of Care (DOC), Responsive Management Nurse Consultant, Executive Director (ED) and residents.

WRITTEN NOTIFICATION: Dietary services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 76 (d)
Dietary services
s. 76. Every licensee of a long-term care home shall ensure that the dietary services component of the nutritional care and dietary services program includes,
(d) availability of supplies and equipment for food production and dining and snack service.

The licensee failed to ensure that they had adequate supplies and equipment for dining service.

Rationale and Summary
During observations of meals, it was noted that there was a shortage of cutlery available to residents and they were being given plastic cutlery to use. Paper bowls were also being used for desserts as there was a shortage of dessert dishes.

Residents made comments about the home using disposable dishes and cutlery because of the shortage of regular supplies.
A Personal Support Worker (PSW) said that they have been using paper bowls, cups, and plastic cutlery during meal service for a couple of months now as they run out of regular dishes and cutlery.

The Food Service Manager shared that an inventory of cutlery was done that resulted in an order for cutlery being placed. They said that the order would take three weeks. The Food Service Manager was not aware that there was a shortage of some regular dishes but said they could order some.

Sources: Observations made during lunch and dinner service; and interviews with residents, Personal Support Worker (PSW) and Food Service Manager (FSM).

WRITTEN NOTIFICATION: Food production

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (d)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu;

The licensee failed to ensure that menu items were prepared according to the planned menu.

Rationale and Summary
The Ministry of Long-Term Care received a complaint regarding sandwiches being made without any butter or margarine put on the bread.

The daily posted menu and the weekly menu for lunch stated a pastrami sandwich on wheat bread. During lunch meal service on 2 West, it was observed that the pastrami sandwich was on white bread and there was no margarine on the bread. A Personal Support Worker (PSW) who was serving the sandwiches to the residents, confirmed that there was no margarine on the pastrami sandwiches and that they were on white bread.

The pastrami sandwich on wheat recipe called for whole wheat bread and to spread each slice of bread with margarine.

Sources: Observations at lunch service; and review of pastrami sandwich on wheat recipe.

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that a resident who required assistance with eating and drinking was not served a meal until someone was available to provide the assistance required.

Rationale and Summary
A resident was being assisted with eating when a Personal Support Worker (PSW) was required to leave to take their scheduled break. That resident was left with their dessert, sitting on the table from 1230 hours until 1237 hours when another staff was available to assist the resident with feeding them their dessert.

Staff leaving to take scheduled breaks during resident meal service interrupted the resident's meal when there was no staff to provide assistance.

Sources: Observations during lunch service; and interviews with Personal Support Workers (PSW).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 1.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or

sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The licensee failed to ensure that when they made a report in writing to the Director regarding a medication error that caused an adverse reaction for a resident, that they included the events leading up to the incident.

Rationale and Summary
The home submitted a Critical Incident (CI) Report regarding a medication incident with a resident. The resident had their medication held for two days.

The CI report did not include why the medication was held on the two days.

Sources: Review of resident's clinical records and Critical Incident (CI) Report; and interview with Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that when they made a report in writing to the Director regarding a medication error that caused an adverse reaction for a resident, that they included the name of the staff member that was present at the incident.

Rationale and Summary
The home submitted a Critical Incident (CI) Report regarding a medication incident with a resident. The resident had their medication held on two days.

The CI report did not include the name of Registered Practical Nurse (RPN) that held the medication.

Sources: Review of resident's clinical records and the Critical Incident (CI) Report; and interview with Registered Practical Nurse (RPN) and Clinical Practice Coordinator.

WRITTEN NOTIFICATION: Administration of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that a resident was administered their medication as specified by the prescriber.

Rationale and Summary
A resident was prescribed medication to be administered by mouth twice daily. The resident did not have their medication administered on two separate dates.

By the resident not receiving this medication as specified by the prescriber, this may have contributed to the worsening of their condition.

Sources: Review of resident's clinical records and Medication Incident Report; interviews with Registered Practical Nurse (RPN) and Clinical Practice Coordinator.

COMPLIANCE ORDER CO #001 Food production

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

Food production

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,

(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

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

The licensee shall:

a) Train all dietary aides that work on 2 West and 3 East on the process for measuring and recording food temperatures at point of service. Also review the Servery Food Temperature policy to ensure staff are aware of the process that is to be followed when temperatures for hot foods are less than 60 degrees Celsius and cold foods are more than 4 degrees Celsius. A record of the content of the training, person who provided the training, and individuals who attended the training must be kept in the home.

b) Conduct three meal service audits per week on 2 West and 3 East of temperatures being taken at point of service for three weeks or until no deficiencies are identified. The audits should capture different meal service times. The audits are to include the date and time the audit is being completed, by whom, the foods

being served, any missing recorded temperatures, any food temperatures outside the range defined in the home's Servery Food Temperature policy and any corrective actions taken. The audit shall be kept available in the home.

Grounds
The licensee failed to ensure that all food in the food production system were stored using methods to prevent food borne illness.

Rationale and Summary
The Ministry of Long-Term Care received a complaint that food served to residents was often cold.

As per the Servery Food Temperature policy temperatures are monitored to ensure food being served is safe to consume. At the start of service the temperature standards for hot food was 60˚C (degrees Celsius) - 76˚C and cold foods were less than 4˚C .

Review of the food temperature records for October 3, 2024 dinner at the start of service in 2 West Servery showed that three meal items were checked for temperatures and were identified to be out of range.

A resident shared that their dinner meal was cold. The inspector took temperatures of three meal items on the resident's plate which were all identified to be out of range.

A resident shared that meals were not hot enough most of the time.

On October 7, 2024, no food temperatures were recorded for the observed lunch meal in the 2 West or 3 East serveries.

The Food Service Manager (FSM) shared that temperatures were to be taken prior to meals being served in the serveries and if temperatures were out of range, corrective actions were to be taken to ensure that they were within proper range.

Failing to take and record temperatures at point of service, and failing to take corrective actions for food items when they did not reach minimum required temperatures, put residents at risk of foodborne illness.
Sources: Observations; interviews with a Dietary Aide (DA) and the Food Service Manager (FSM); review of temperature records and Servery Food Temperature Policy H003 revised January 2022.

This order must be complied with by November 29, 2024.

COMPLIANCE ORDER CO #002 Menu planning

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Update the daily menus and the weekly menus posted on 2 West and 3 East to ensure they match the menu cycle that was reviewed by the Residents' Council.
b) The Food Service Manager and/or designate Dietary Manager will review and revise production sheets for the menu cycle, including forecasted quantities, to ensure there is enough planned menu items available to residents, based on the need for show plates, and the ability to offer residents a second portion of their

choosing.
c) Conduct a daily audit of each meal in 2 West and 3 East. The audit shall include the date, the meal, person completing the audit, posted menu items, if any substitutions what they were and why, any shortages of food where residents were not able to be served their requested menu item, and any concerns about the meal expressed by the residents. The Food Service Manager and Executive Director will review the audits for any deficiencies or concerns and will note actions taken. Audits will be completed for three weeks or until there are no deficiencies and be kept available in the home.

Grounds
The licensee failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary
A few residents said that they frequently do not get served items that are on the posted menu board. They stated at times they do not like the changes and will eat items they have available in their room.

A resident said that there were sometimes several food shortages without substitutions in the home.

On October 3, 2024, the menu items posted on the menu were not available at dinner in the home. It was identified that there was not enough of one of the main entrée options at dinner for the residents.

The Food Service Manager (FSM) agreed that the menu changes were not made on the posted menu.

On October 4, 2024, at lunch, the posted menu items were not shared throughout the home. The menu changes were updated in the kitchen, but those changes were not reflected in the posted menus throughout the home.

By not offering the planned menu items or having insufficient quantities of planned menu items available at meal service impacts the quality of services provided by the long-term care home, specifically a pleasurable dining service for the residents and poses the risk of residents refusing meals.

Sources: Observations of meals and posted daily and weekly menus; and interviews with multiple residents, a Personal Support Worker (PSW), and the Food Service Manager (FSM).

This order must be complied with by November 29, 2024.

COMPLIANCE ORDER CO #003 Dining and snack service

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
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:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Review the diet order binder that the Personal Support Workers (PSW) utilize during meal service on 2 West to ensure that it includes the current residents and

their dietary information.
b) Develop a plan as to how the staff will ensure that the the diet order binder on 2 West will be kept up to date to included current residents' dietary information. The plan will include what is to be included in the binder, who will be responsible for updating and when the updating is to occur. The plan will be kept available in the home.
c) Train the dietary aides on 2 West on the process they are to follow to ensure that they are aware of the residents' diets, special needs and preferences during meal service. A record of the content of the training, person who provided the training, and individuals who attended the training shall be kept in the home.
d) Conduct three meal service audits per week on 2 West to ensure that dietary aides are following the process to ensure they are aware of the resident's diets, special needs and preferences at the time of plating the residents' meals. The audits should capture different meal service times. These audits will include the date and time the audit is being completed, by who, the name of the dietary aide serving, if the proper process was followed, any deficiencies, and any corrective actions taken. The audits shall be completed for a three week period or until no deficiencies are identified, and kept available in the home.

Grounds
The licensee failed to ensure that there was a process to ensure that food service workers and other staff assisting residents on 2 West were aware of the residents' diets, special needs and preferences.

Rationale and Summary
During lunch meal on October 3 and October 4, 2024, and dinner meal on October 3, 2024, on 2 West, Dietary Aides (DA) were not referencing the MealSuite system or the diet order binder for the residents' diets, textures, or any resident specific requirements. The Personal Support Workers (PSW) during these meals on 2 West

were referencing the diet order binder, however they noted that the diet order binder did not have all current residents and their respective diet information in the binder. Dietary Aides were relying on the PSWs to tell them the diet type, texture, and any specific requirements.

Review of the 2 West diet order binder showed that six residents that currently resided on 2 West were not included in the binder.

The Food Service Manager (FSM) said that the process was that the PSW serving was to state the resident's name for whom the meal was for and the Dietary Aide plating the food was to look in the MealSuite system for the resident's diet, texture, allergies, food likes and dislikes and any special requirements that the resident was to have.

The PSW not having an up-to-date diet order binder and the Dietary Aide not referencing resident information in MealSuite, put residents at risk of being served the wrong diet, texture or missing special requirements.

Sources: Observations of meals in 2 West; interviews with Personal Support Worker (PSW), Dietary Aides (DA), the Food Service Manager (FSM); and review of 2 West Diet Order Binder and MealSuite system on 2 West.

This order must be complied with by November 29, 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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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.