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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: March 11, 2025

Inspection Number: 2025-1193-0002

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Orchard Villa, Pickering

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20 - 21, 24 - 28, 2025 and March 3 - 7, 10 -11, 2025.

The inspection occurred offsite on the following date(s): February 27, 2025.

The following intake(s) were inspected:
• Four intakes and Critical Incidents (CIs) were related to prevention of abuse and neglect.
• An intake from inspection 2024-1193-0004, related to O. Reg. 246/22 - s. 58 (1) 3, with a Compliance Due Date (CDD) of January 7, 2025.
• An intake from inspection 2024-1193-0004, related to O. Reg. 246/22 - s. 58 (4), with a CDD of January 7, 2025.
• Three intakes and CIs were related to outbreak of infectious diseases.
• An intake was related to a complaint of air temperature.
• An intake and a CI were related to a missing resident.
• An intake and a CI were related to a fall with injuries.

The following intakes were completed in this inspection: Three intakes and CIs were related to falls with injuries.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1193-0004 related to O. Reg. 246/22, s. 58 (1) 3.

Order #002 from Inspection #2024-1193-0004 related to O. Reg. 246/22, s. 58 (4).

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

Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
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: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the Pine Home Area Staff Meeting Room door was kept closed and locked when not being supervised by staff.

Inspector conducted an Infection Prevention and Control (IPAC) Tour and found on Pine Home Area, a Staff Meeting Room door that was left open, unlocked, and unsupervised by staff.

The Student Nurse, the Registered Practical Nurse (RPN), and the Registered Nurse (RN), all confirmed that the Staff Meeting Room was a non-resident space, and that the door was to be closed and locked at all times.

The RN immediately locked and secured the Staff Meeting Room.

Sources: Inspector observation, Interviews with staff.

Date Remedy Implemented: February 24, 2025

WRITTEN NOTIFICATION: Plan of Care

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 resident's activity of daily living (ADL) schedule was followed. On an identified day, the on-duty RN had permitted the resident to be engaged in an ADL outside of the scheduled time. Later that morning, the resident had eloped but was brought back to the facility with a minor injury.

Sources: Resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (c)
Infection prevention and control program
s. 23 (2) The infection prevention and control program must include,
(c) daily monitoring to detect the presence of infection in residents of the long-term care home;

The licensee has failed to ensure that the IPAC Program included daily monitoring to detect the presence of infection in residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that there was an IPAC Program that included daily monitoring of residents to detect the presence of infection in residents and that it was complied with.

Specifically, Registered Staff failed to comply with the home's Infection Surveillance Policy and document monitoring for signs and symptoms of infection on the Daily Infection Signs and Symptoms Surveillance Forms (DISSSF) upon the resident's

symptom onset and/or for the new onset of symptoms for residents #006, #007, #008, #009, #033, and #036.

Sources: Critical Incident Report (CIR), the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #007's and #009's electronic health records, and interviews with staff.

1. A review of the home's Outbreak Line List indicated that residents #006 and #008 exhibited infectious symptoms on identified dates. However, such information were not documented in the home's DISSSF form.

Sources: CIR, the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #006's and #008's electronic health records, and interviews with staff.

2. A review of the home's Outbreak Line List indicated that resident #033 had developed an infectious disease on an identified date but their infectious symptoms were not documented in the home's DISSSF form.

Sources: CIR, the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #033's electronic health records, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following

has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure the RN immediately reported an allegation of a resident-to-resident physical abuse to the Director.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

On an identified day, a physical altercation between two residents had occurred and resulted in a skin tear for one of the residents. The RN had reported to their supervisor and on-call manager, but did not report to the Director until the following day.

Sources: CIR; Progress notes and Interview with the staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

The licensee has failed to ensure that the resident was transferred correctly between surfaces on an identified date. As per the resident's plan of care, the

resident required a specific transferring technique by the staff. An observation was made where two Personal Support Workers (PSWs) had used an incorrect technique to transfer the resident between two surfaces.

Sources: Inspector's observation, interview with staff.

WRITTEN NOTIFICATION: Mobility devices

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 43
Mobility devices
s. 43. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis.

The licensee has failed to ensure that mobility devices, including wheelchairs, were available at all times to the resident who required them on a short-term basis. The facility did not provide the resident with an appropriate temporary wheelchair that allowed them to be seated in the correct position.

Sources: Inspectors observations, residents progress notes, interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #007 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 monitoring tools that were part of the falls prevention and management program to reduce the incidence of falls and the risk of injury for the resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that there is a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

Specifically, the staff did not comply with the requirement of the program to complete the head injury routine (HIR) after the resident's witnessed fall with head injury.

Sources: Resident's PointClickCare assessments, home's fall prevention and management program policy, and staff interview.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure the individualized plan for incontinent care for the resident was implemented.

As per the resident's plan of care they required two staff to assist with incontinence care. On an identified date, the PSW had provided incontinence care independently by utilizing a technique that was not documented in the resident's plan of care.

Sources: Resident clinical records; Investigation notes with the PSW; Staff interview.

WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure strategies were developed and implemented to respond to the resident's behaviors during care.

The resident was known to exhibit responsive behavior during care and a strategy was to be implemented by staff to reduce such behavior. As such, two staff were required when providing care to the resident. On an identified date, the PSW had provided incontinence care alone by utilizing a technique that was not indicated in the resident's plan of care. As per the Director of Care (DOC), an alternate strategy could have been implemented at the time of care.

Sources: Resident clinical records; Investigation notes with the PSWs; Staff interviews.

WRITTEN NOTIFICATION: Responsive behaviors

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of the resident, including interventions and responses were documented. The registered staff were instructed to document on the resident's responsive behaviors and intervention effectiveness on every shift in the resident's electronic documentation system. When reviewed, there were multiple shifts where the documentation was not completed.

Sources: The resident's electronic charting, and staff interview.

WRITTEN NOTIFICATION: Maintenance Services

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that one of the steamtables in the kitchen was kept in good repair.

During an onsite inspection, the inspector was informed that three steam wells in a kitchen's steam table were not functioning properly during lunch service. The Cook and the Dietary Aide (DA) stated they had informed the Food Service Manager about the issue a week prior; however, the manager was no longer employed at the home. According to the food temperature policy, the home must ensure that all equipment used for hot and cold holding was functioning properly.

The Regional Food Service Supervisor (RFSS) noted that staff had reported the malfunctioning equipment two hours before the meal service, yet the steam table was still used to hold meal items for the lunch service. Two meal items placed in the steam wells had temperatures of 45-49 degrees Celsius (˚C), which fell within the danger zone of 4-60˚C for food contamination. This temperature range can increase the risk of foodborne illness among vulnerable residents.

Sources: Observations, policy #DP-04-01: Food Temperature - Holding and Distribution Safety Requirements, created in November 2024, and staff interviews.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

According to IPAC Standard, s. 10.4(h), the licensee shall ensure support for residents to perform hand hygiene prior to receiving meals and snacks.

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

An IPAC Inspection was conducted in accordance with the IPAC Checklist.

An observation was made around a mealtime where staff did not provide or assist with hand hygiene for a group of residents.

Sources: IPAC Checklist, the home's IPAC policies/procedures, Inspector observations and staff interviews.

COMPLIANCE ORDER CO #001 Food production

NC #013 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:

1) The Regional Food Service Supervisor or their designate will provide in-person training to all cooks and dietary staff, including any staff cross-trained to work as dietary staff on the following:

a) Taking and recording end-point cooking and point-of-service temperatures, including the date, meal type, and corrective actions taken.
b) Proper food handling practices during preparation and service.
c) Keep a record of training sessions, including the content, trainer's name, and attendees.

2) The Food Service Manager (FSM) or designate will conduct three meal service audits per week for four weeks on:
a) Proper food handling, serving, and hand hygiene practices of dietary staff. Audits should include staff name and designation, date, and person completing the audit.
b) Temperatures being taken at end-point-cooking and point of service. The audits should capture different meal service times and dining areas, person completing the audit, foods being served, any missing recorded temperatures, any food temperatures outside the range defined by the home's Food Temperature Policy and any corrective actions taken.
c) Weekly, the FSM will analyze the audit results and provide further corrective actions to staff based on observed trends. A documented record of audits will be kept and made available upon request.

Grounds

The licensee has failed to ensure that hot menu items were served using methods to prevent adulteration, contamination, and food borne illness.

The home's Food Temperature - Holding and Distribution Safety directed staff to regularly record food temperatures on designated logs; report and document any corrective actions taken if food temperatures fall outside the safe range; serve hot foods at temperatures between 60˚C and 82˚C, reheat foods, if needed, until internal temperature is correct.

During an inspection before lunch in the main dining room, the inspector found that three steam wells were not working properly. The Regional Food Service Supervisor (RFSS) had been informed two hours before lunch, but the steam wells were still used to hold food. The inspector also observed the Dietary Aide (DA) preparing sandwiches with gloves on. They touched serving surfaces and removed bread from bags without changing gloves or washing their hands.

The inspector asked another DA to check the temperatures of two out of six meal items placed in these steam wells, which were between 45˚C and 49˚C, below the safe food temperature range of 60˚C to 82˚C.

The DA indicated that they were instructed not to reheat the menu items with low food temperatures and to serve them as they were. Additionally, the food temperature logs for this meal service did not include the menu items with temperatures that were below the safe range, nor did they document any corrective actions taken.

Failure to take corrective actions to ensure the identified items were served at safe temperatures between 60-82˚C, increased the risk of food adulteration and foodborne illness in a vulnerable population.

Sources: Observations, policy #DP-04-01: Food Temperature - Holding and Distribution Safety Requirements, created in November 2024, Point of service food temperature logs, and staff interviews.

This order must be complied with by May 31, 2025

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

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

1-The IPAC Lead and/or designate will educate all Registered Staff, including Agency Staff, on the home's policies, procedures and process for monitoring and recording of a resident's signs and symptoms indicating the presence of infection, on every shift. Keep a written record indicating the name and designation of the home's active Registered Staff, including Agency Staff.

2-Keep a record of the education, that must include: the content of the education, the name of the educator and their designation, the date and time the education was provided, and the name, designation and signature of the Registered Staff that was educated.

3-Upon completion of Registered Staff education, the IPAC Lead and/or designate will:

-If the home is not in outbreak: Audit the health records of any and all residents with signs and symptoms indicating the presence of infection on a weekly basis for four weeks. The home will keep a written record of all audits conducted, that must include: the name of the auditor, the date/time of the audit, the resident's name and/or room number, the resident's signs and symptoms of infection for every shift,

if the resident's signs and symptoms monitoring was recorded for all shifts, and any corrective actions taken if there is any resident monitoring/recording missing, on any shift, identified through the auditing process.

-If the home is in a CONFIRMED outbreak: Audit the health records of any and all residents with signs and symptoms indicating the presence of infection on a daily basis, including weekends and holidays, until the outbreak is declared over. The home will keep a written record of all audits conducted, that must include: the name of the auditor, the date/time of the audit, the resident's name and/or room number, the resident's signs and symptoms of infection on every shift, if the signs and symptoms monitoring was recorded for all shifts, and any corrective actions taken if there is any resident monitoring/recording missing, on any shift, identified through the auditing process.

4-Make all written records available to Inspectors upon request.

Grounds

The licensee has failed to ensure that symptoms indicating the presence of infection were monitored and the symptoms recorded on every shift for resident's #006, #007, #008, #009, #033, and #036.

IPAC Lead confirmed that Registered Staff were to document the monitoring of a resident's signs and symptoms of infection on the DISSSF or in the resident's progress notes.

The Regional IPAC Specialist confirmed that Registered Staff were to monitor symptomatic residents on every shift and document the monitoring in a progress note.

Three CIR's were received by the Director related to disease outbreaks.

1. A review of the home's Outbreak Line List indicated that residents #007 and #009 were infected with an infectious disease on identified dates. However, their infectious symptoms were not documented in the home's DISSSF form on identified shifts.

The Regional IPAC Specialist confirmed that the home was aware of documentation gaps in resident monitoring of signs and symptoms of infection by Registered Staff on the identified shifts.

Failure to ensure that Registered Staff monitored and recorded residents #007 and #009's signs and symptoms of infection, on every shift, placed the resident's health at increased risk and for their symptoms to go unnoticed by Registered Staff.

Sources: CIR, the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #007 and #009's electronic health records, and interviews with staff.

2. A review of the home's Outbreak Line List indicated that residents #006 and #008 were infected with an infectious disease on identified dates. However, their infectious symptoms were not documented in the home's DISSSF form on multiple shifts.

The Regional IPAC Specialist confirmed that the home was aware of gaps in the documentation of resident's monitoring of signs and symptoms of infection by Registered Staff on the identified shifts.

Failure to ensure that Registered Staff monitored and recorded residents #006 and #008's signs and symptoms of infection, on every shift, placed the resident's health at increased risk and for their symptoms to go unnoticed by Registered Staff.

Sources: CIR, the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #006 and #008's electronic health records, and interviews with staff.

3. A review of the home's Outbreak Line List indicated that residents #033 and #036 were infected with an infectious disease on identified dates. However, their infectious symptoms were not documented in the home's DISSSF form on identified shifts.

The Regional IPAC Specialist confirmed that the home was aware of gaps in the documentation of resident's monitoring of signs and symptoms of infection by Registered Staff on the identified shifts.

Failure to ensure that Registered Staff monitored and recorded residents #033 and #036's signs and symptoms of infection, on every shift, has placed the resident's health at increased risk and for their symptoms to go unnoticed by Registered Staff.

Sources: CIR, the home's Infection Surveillance and Managing Outbreaks Policies, Outbreak Line List, Daily Infection Signs and Symptoms Surveillance Forms, resident #033 and #036's electronic health records, and interviews with staff.

This order must be complied with by June 2, 2025

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

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.