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: December 16, 2024

Inspection Number: 2024-1071-0006

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Oshawa, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 12-15, 18-22, 24-26, 2024.

The following intakes were inspected in this complaint inspection:
-One intake related to concerns regarding a bed refusal.
-One intake related to concerns regarding emotional abuse and conduct of staff.
-One intake related to concerns regarding safety and security in the home.
-One intake related to concerns regarding falls prevention.

The following intake was inspected in this Critical Incident (CI) inspection:
-Two intakes related to allegations of neglect of residents.
-One intake related to an outbreak of disease of public significance.
-Two intakes related to fall with injury.

The following intakes were inspected:
-Follow up to Compliance Order (CO) #001, related to FLTCA, 2021 - s. 6 (1) Plan of care with compliance due date (CDD) on October 4, 2024.

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

-Follow up to CO #002, related to O. Reg. 246/22 - s. 138 (1) (a) (ii) Safe storage of drugs, with CDD on October 11, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1071-0003 related to FLTCA, 2021, s. 6 (1)
Order #002 from Inspection #2024-1071-0003 related to O. Reg. 246/22, s. 138 (1) (a) (ii)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: WHEN REASSESSMENT, REVISION IS REQUIRED

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's falls prevention plan of care was revised when the resident's care needs changed and care set out in the plan had not been effective.

Rationale and Summary
A critical incident report (CI) was submitted to the Director for a fall of a resident.

Clinical records for resident indicate that the resident's was at risk for falls . Review of the resident's progress notes indicate that resident had fluctuating cognition. Interview with the Assistant Director of Care (ADOC) indicated that the resident was known to be restless and have sleep disturbance. Interview with registered practical nurse (RPN) they indicated that restlessness and sleep disturbance should included in the plan of care and that interventions to support restlessness and sleep should be added. During interviews with personal support worker (PSW) and registered nurse (RN) they acknowledged that the resident was removing the fall prevention intervention at the time of the fall.

Failure to revise the resident's plan of care, and implementing new interventions when the intervention in the plan of care was not effective, could have contributed to the resident's fall and sustaining an injury.

Sources: A Critical Incident Report , clinical records for a resident, and interviews with staff.

WRITTEN NOTIFICATION: LICENSEE CONSIDERATION AND APPROVAL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (a)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

The licensee has failed to review an applicant's assessments and information and approve the applicant's admission to the home unless, the home lacks the physical facilities necessary to meet the applicant's care requirements.

Rationale and Summary
A complaint was received by the Director related to a bed refusal for an applicant.

Review of the home's Decision Communication Form (DCF), confirmed that the home was withholding an application due to a lack of physical facilities to meet their current care needs for transportation reasons. Furthermore, the DCF indicated that the applicant could reapply in the future if Extendicare had better transportation services.

Review of a complaint received from Home and Community Care Support Services (HCCSS), confirmed that the homes cited reasons for an applicant's rejection were not valid, and HCCSS was not in agreement.

Office Manager (OM) and SW , both confirmed, historically, the home's wheelchair accessible transportation services (WATS) were not reliable. Furthermore, SW confirmed that the applicant's bed referral was rejected due to the home's unreliable WATS to attend their treatment. OM and SW both confirmed that they were aware of High Intensity Needs Funding related to resident transportation for treatment. OM confirmed that they were recently made aware that they procured reliable WATS. Electronic communication with SW, confirmed that the applicant was placed on the home's waitlist as the home had procured reliable WATS.

Failure to ensure that the licensee approved applicant's admission, unless the home lacks the physical facilities necessary to meet the applicant's care requirements, has placed the resident's physical and emotional well-being at risk.

Sources: The home's Screening for Admission Policy, the home's DCF, LTCH's DCF provided to the applicant, application health records, electronic communication between the home/HCCSS, and SW, and interviews with staff.

WRITTEN NOTIFICATION: WRITTEN NOTICE IF LICENSEE WITHHOLDS APPROVAL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (d)
Authorization for admission to a home
s. 51 (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(d) contact information for the Director.

According to FLTCA, 2021, s. 51(10), persons referred to in subsection (9) are the applicant and the appropriate placement co-ordinator.

When the licensee withheld an applicant's approval for admission, the licensee failed to give to persons described in subsection (10) a written notice setting out the contact information for the Director.

Rationale and Summary
A complaint was received by the Director related to a bed refusal for an applicant.

Review of applicant's referral and review of the home's DCF, confirmed that the home was withholding applicant's application and did not include the contact number for the Director. SW provided Inspector with the applicant's DCF, and confirmed the details in the DCF, which did not include the contact number for the Director.

Failure to ensure providing the contact number for the Director has impeded the ability for the applicant or their caregiver to contact the Director to advocate on the applicant's behalf.

Sources: The home's Screening for Admission Policy, LTCH's DCF for the applicant, application health records, electronic communication between the home/HCCSS, and SW , and an interview with the SW.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

According to O. Reg., 246/22, s. 108c(1) 3, the response provided to a person who made a complaint shall include, an explanation of what the licensee has done to resolve the complaint or that the licensee believe the complaint to be unfounded, together with the reasons for the belief.

The licensee has failed to ensure that for every written or verbal complaint that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

Rationale and Summary
A complaint was received by the Director related to a safe and secure home for the residents.

Review of the home's Complaint Binder confirmed a complaint was received related to their concern of the home's safety and security.

Review of the home's complaint investigation records confirmed that the home was unable to investigate and resolve the complaint within ten business days and was forwarding the concern to corporate office for further guidance and/or direction. Further review of the complaint investigation record documentation confirmed that the home had contacted a resident, not the complainant, to inform them that they

were awaiting further guidance and/or direction from corporate office and did not include the date by which the complainant can reasonably expect a resolution.

The Administrator confirmed that there was no further guidance and/or direction from corporate office and the responsibility was left at the home's discretion.

The Administrator confirmed that the home had investigated diverse options to resolve the concern, however, they could not be implemented as a result of the home's infrastructure. Additionally, Administrator confirmed that the home's management team had discussions, but a decision and/or process had not yet been implemented.

Review of the home's complaint response letter confirmed that their concerns were resolved. The complaint response letter did not provide an explanation of what the licensee had done to resolve the complaint. ADOC and Administrator, both confirmed that the complaint response letter did not provide an explanation of what the licensee had done to resolve the complaint.

The Administrator confirmed that they were uncertain if the home had provided the complainant with an update after consulting with corporate office or what actions the home had taken to resolve their complaint. Furthermore, an interview with the complainant confirmed that the home did not inform them of any direction from corporate office or what, if any, actions the home had taken to resolve their complaint.

Failure to ensure that for every written or verbal complaint that cannot be investigated and resolved within ten business days, an acknowledgement of receipt of the complaint was provided within ten business days of receipt of the complaint, which included the date by which the complainant can reasonably expect a resolution, and that a follow-up response provided an explanation of what the licensee had done to resolve the complaint, has impeded the complainants ability to

advocate for the resident.

Sources: The home's Complaints and Customer Service Policy, the home's Complaint Binder and Investigation Records, and an interview with the Administrator.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

1. The licensee failed to ensure that when the resident expressed a concern a documented record was kept in the home.

Rationale and Summary
A complaint was lodged to the Director related to a resident's treatment plan.

The clinical health record for the resident was reviewed. The DOC indicated that the LTCH had conducted an investigation related to this complaint and the complaint

was substantiated. The Administrator confirmed that a written record of the compliant-related is not kept in the LTCH's complaints binder.

Failing to ensure that records of the complaint related to the resident were documented and kept in the home, may have impacted how issues were addressed.

Sources: Resident's health records, LTCH's Complaints Binder 2024, resident's complaint, interviews with resident, DOC, and Administrator.

2. The licensee failed to ensure that when the resident expressed a concern, a documented record was kept in the home.

Rationale and Summary
A complaint was lodged to the Director related to care of a resident.

The resident's clinical health record was reviewed. The record indicated that the Nutrition Manager (NM) spoke with the resident regarding this concern, and interventions were implemented.

The NM indicated that the LTCH had conducted an investigation related to this complaint and the complaint was unsubstantiated. The administrator confirmed that a written record of the compliant was not kept in the LTCH's complaints binder.

Failing to ensure that records of the complaint related to the resident were documented and kept in the home, may have impacted how issues were addressed.

Sources: Resident's health records, LTCH's Complaints Binder 2024, a complaint, and interviews with a resident, staff, and the Administrator.

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #006 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 drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A complaint was lodged to the Director related to the resident's medication administration.

The clinical health record for the resident was reviewed. The clinical health record for the resident failed to identify directions by the prescriber. The medication administration record revealed that the medication was administered by a registered staff on a specific day.

Failure to administer medications by directions for use by the prescriber, placed residents at risk for harm.

Sources: Resident's clinical record, and interviews with registered staff and the DOC.

WRITTEN NOTIFICATION: APPROVAL BY LICENSEE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 179 (5)

Approval by licensee
s. 179 (5) The licensee shall give the appropriate notice under paragraph 1 or 2 of subsection (3) within three business days of receiving the additional information provided under subsection (4).

According to O. Reg., 246/22, s. 179(4), where the licensee makes a request in writing to the appropriate placement coordinator for additional information that in the placement coordinator's opinion is relevant to the licensee's determination of whether to give or withhold approval for the applicant's admission to the home, the placement coordinator shall provide the information to the licensee.

The licensee has failed to give the appropriate notice under paragraph 1 or 2 of subsection (3) within three business days of receiving the additional information provided in subsection (4).

Rationale and Summary
A complaint was received by the Director related to a bed refusal for an applicant.

Review of electronic communication between the HCCSS and the home, confirmed the home did not provide a response after the requested information for the applicant was provided, for a period of time until when the applicant was accepted to the home's admission waitlist. Electronic communication with SW confirmed that an applicant was accepted to the home's admission waitlist due to the home recently procuring reliable wheelchair accessible transportation services and not based on any new information or assessments.

Failure to ensure to giving the appropriate notice, within three business days, of receiving requested information for an applicant has significantly delayed the applicant's approval and admission.

Sources: Electronic communication between the home/HCCSS, and SW, and an interview with staff.

COMPLIANCE ORDER CO #001 NURSING AND PERSONAL SUPPORT SERVICES

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

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. Communicate with nursing and personal care staff on the home's updated Staffing Contingency Plan.
2. Keep a written record of the communication provided to nursing and personal care staff on the home's updated Staffing Contingency Plan.
3. The DOC will educate the management team and any staff responsible for implementing actions and/or providing direction to staff during a staffing shortage, to ensure understanding of and proficiency in that role.
4. Keep a written record of education provided by the DOC, that name of the staff member educated, their designation, the date of education, and the contents of the education. Provide the written records to the Inspector immediately upon request.
5. For four weeks, on each shift that a staffing shortage occur, keep a written record that includes the date and shift, the number of PSW shortages, and any actions taken and/or implemented to fill the shortage. Provide the written record to

Inspector immediately upon request.

Grounds
The licensee failed to ensure that the home's staffing plan included a back-up plan for personal care staffing that addresses situations when staff cannot come to work.

Rationale and Summary
A CI was received by the Director for an allegation of neglect, during a PSW staffing shortage.

Review of the CI, confirmed that residents reported to an RPN, a complaint related to not receiving care due to PSW staffing shortages during a night shift. Review of the home's Staffing Contingency Plan confirmed that if the home was unable to cover an RPN/RN shift, it directed to contact a Staffing Agency to fill the shortage, this direction was not indicated for a PSW staffing shortage. DOC confirmed that the home's PSW Staffing Contingency Plan, did not indicate or provide direction to utilize a staffing agency to fill a critical PSW staffing shortage and should have.

RPN and DOC both confirmed that at the time of the incident the home area did not have a full complement of PSWs during a shift. Review of electronic mail from scheduling coordinator confirmed that the home did not utilize a Staffing Agency to fill the PSW shortages on a specific date. Review of the home's internal investigation records of the incident, confirmed documentation of long-term interventions/actions/strategies taken to ensure resident safety was to utilize Agency staffing for PSW's in critically short staffing crisis.

Failure to ensure that the home's staffing plan included a back-up plan for personal care staffing that addresses situations when staff cannot come to work has placed resident's health and well-being at risk.

Sources: A CI, the home's Investigation notes, electronic communication with

scheduling department, the home's Staffing Contingency Plan, and interviews with staff.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #002 NURSING AND PERSONAL SUPPORT SERVICES

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (e)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

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. Update the home's PSW Staffing Contingency Plan, to include a back-up plan for personal care staff that addresses situations when staff cannot come to work.
2. Update the home's Staffing Contingency Plan to include any changes to the nursing and personal care staff processes and/or compliment.
3. Update the home's Staffing Contingency Plan in accordance with the home's annual Staffing Plan evaluation, as applicable.
4. Keep a record of the home's updated Staffing Contingency Plan and provide it to Inspector immediately upon request.

Grounds
The licensee has failed to ensure that the staffing plan was evaluated and updated

at least annually in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices.

Rationale and Summary
A CI was received by the Director for an allegation of neglect, during a PSW staffing shortage.

DOC confirmed that the home's process during a staffing shortage, if the home was unable to fill the shortage, was to utilize a staffing agency. Review of the home's Staffing Contingency Plan confirmed that if the home was unable to cover an RPN/RN shift, it directed to contact a staffing agency to fill the shortage, however, this direction was not indicated during a PSW staffing shortage. DOC confirmed that the home's Staffing Contingency Plan, was updated, but the date had not been changed. Additionally, DOC confirmed that the home's PSW Staffing Contingency Plan, did not indicate or provide direction to utilize a staffing agency to fill PSW staffing shortages and should have. DOC confirmed that they had recently increased the PSW staffing compliment throughout the home, as to improve the quality of resident care and that the increase in PSW staffing compliment had not been updated on the home's Staffing Contingency Plan.

Failure to ensure that the home's staffing plan was evaluated and updated at least annually, in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, has placed residents' health and safety at increased risk.

Sources: A CI, the home's Staffing Contingency Plan, and an interview with the DOC.

This order must be complied with by January 31, 2025.

COMPLIANCE ORDER CO #003 NURSING AND PERSONAL SUPPORT SERVICES

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 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 home will keep a written record for each evaluation of the home's Staffing Plan, that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

2. Provide all written records for evaluations of the home's Staffing Plan to Inspector immediately upon request.

Grounds
According to O. Reg., 246/22, s. 35(3)(e) the licensee's staffing plan must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who

participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
A CI was received by the Director for an allegation of neglect, during a PSW staffing shortage.

Review of the home's Staffing Contingency Plan, did not indicate the date of an evaluation, the names of persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. DOC confirmed that the home did not have a written record of the home's Staffing Plan Evaluation that was conducted on a specific date. The DOC confirmed that the home's designated Quality Lead was responsible to ensure a written record was kept of the home's Staffing Contingency Plan evaluation. Furthermore, the DOC confirmed that the home did not currently have a designated Quality Lead.

Failure to ensure a written record of the home's Staffing Contingency Plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, has placed resident care at increased risk during a staffing shortage.

Sources: A CI, the home's Staffing Contingency Plan, and an interview with the DOC.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #004 CONTINUOUS QUALITY IMPROVEMENT DESIGNATED LEAD

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 167 (1)
Continuous quality improvement designated lead

s. 167 (1) Every licensee of a long-term care home shall ensure that the home's continuous quality improvement initiative is co-ordinated by a designated lead.

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 home is to designate a Lead that is responsible for the home's continuous quality improvement initiative in accordance with the legislation/regulation.

Grounds

The licensee failed to ensure that the home's continuous quality improvement initiative is coordinated by a designated lead.

Rationale and Summary

A CI was received by the Director for an allegation of neglect, during a PSW staffing shortage.

Review of the home's Ministry of Long-Term Care Entrance Binder, which indicated contact Information for the home's program leads, confirmed that the home's role for a designated Quality Lead was vacant. DOC confirmed that the home's designated Quality Lead was responsible to ensure a written record of any of the home's annual evaluations. Furthermore, DOC confirmed that the home does not currently have a designated Quality Lead.

Failure to ensure that the home's continuous quality improvement initiative was coordinated by a designated lead, has impeded the home's quality improvement initiative and has placed the residents' quality of life at increased risk.

Sources: A CI, the home's Ministry of Long-Term Care Entrance Binder, and an interview with the DOC.

This order must be complied with by January 31, 2025

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

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.