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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date August 12, 2022
Inspection Number 2022_1528_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Ina Grafton Gage Home of Toronto

Long-Term Care Home and City
Ina Grafton Gage Home, Scarborough

Lead Inspector
Julie Ann Hing (649)

Additional Inspector(s)
Kehinde Sangill (741670) was present during this inspection.

Inspector Digital Signature
Julie ann Hing
Digitally signed by Julie ann Hing
Date: 2022.10.24 07:14:13 -04'00'

AMENDED INSPECTION REPORT SUMMARY

This inspection report has been amended to change the compliance due dates for Compliance Orders (COs) #001, #002, #003, #004 and #005 from November 8, 2022, to November 28, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30, 31, June 1, 2, 3, 7, 8, 9, 10, 13, July 21, 22, 25, off-site on June 14, 17, July 6, 7, 23, and 26, 2022.

The following intake(s) were inspected:

- Intake #008240-22 was a complaint related to skin and wound and falls prevention and management.
- Intake #010353-22 was a follow-up related to plan of care.

Previously Issued Compliance Order(s)

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

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Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
FLTCA, 2021	s. 6 (7)	2022_1528_0001	001	Julie Ann Hing (649)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Skin and Wound Prevention and Management

WRITTEN NOTIFICATION RESIDENTS' BILL OF RIGHTS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 3 (1) 19 (iv)

The licensee has failed to ensure that every resident has the right to have their personal health information within the meaning of the Personal Health Information Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

Rationale and Summary

A resident's electronic-medication administration record (e-MAR) was unattended and visible on the medication cart on a home area. The Nurse Practitioner (NP) advised that the screen should have been locked.

Failure of staff to lock the screen when unattended could allow unauthorized access to the resident's personal health information.

Sources:

Observation of unlocked e-MAR screen, interviews with NP and other staff.
[649]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.55 (2) (b) (iii)

The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Rationale and Summary

No referral was sent to the Registered Dietitian (RD) for an identified site of altered skin integrity therefore the resident was not assessed by the RD.

Sources:
Review of resident's clinical records, review of RD referrals and assessments, interviews with Registered Practical Nurse (RPN), Food Service Manager (FSM), and other staff.
[649]

WRITTEN NOTIFICATION SAFE STORAGE OF DRUGS

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

Non-compliance with: O. Reg. 246/22 s.138. (1) (a) (ii)

The licensee has failed to ensure that, drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary
A medication cart was observed unlocked when unattended, and residents' medications were accessible. A resident was observed beside the unlocked medication cart. The NP indicated they could not secure the medication cart as another registered staff had the key.

Failure of staff to lock the medication cart when unattended placed residents at risk of ingesting medications that were not prescribed for them.

Sources: Observation of unlocked medication cart, interviews with NP, and Director of Care (DOC).
[649]

COMPLIANCE ORDER CO#001 PREVENTION OF ABUSE AND NEGLECT

NC#004 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 24 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act. 2021

Compliance Plan *FLTCA, 2021, s. 155 (1) (b)*

Specifically, the licensee shall prepare, submit and implement a plan to ensure residents are not neglected by the licensee or staff.

The plan must include, but is not limited to, the following:

(a) An audit process to ensure thorough documentation of treatments and completion of weekly skin assessments for all areas of altered skin integrity.
(b) A process to ensure timely transcription of physician and NP treatment orders.
(c) A process to identify signs and symptoms of altered skin integrity infection and a process to respond immediately to potential infection.
(d) Assessing and identifying signs and symptoms of pain in residents with altered skin integrity.
(e) A process to ensure immediate access of orders for PRN pain medication.
(f) Registered staff (RN and RPN) training in the above-mentioned areas.
(g) The plan should include identified staff roles and responsibilities for the implementation and evaluation of the above process. A timeline is to be established for the implementation of each component of steps A through G within the compliance due date.

Please submit the written plan for achieving compliance for inspection 2022_1528_0002 to Julie Ann Hing, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by August 26, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

In accordance with the definition identified in Ontario Regulation 246/22 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Rationale and Summary

The following evidence demonstrated neglect.

(a) Two sites of altered skin integrity were not mentioned in any assessments and there was no documentation of the provision of treatment.

(b) Treatments ordered for multiple areas of altered skin integrity were not transcribed when there was documentation of deterioration.

(c) Physician's orders were not transcribed:

The physician identified potential infection and ordered diagnostic testing. The physician also ordered daily treatment to another area of altered skin integrity.

(i) The first nurse signed that the above orders were transcribed. Upon review they realized that they had not transcribed the orders and stated that they assumed it had been done by another staff.

(ii) The orders were not co-signed by a second nurse until 12 days later.

(iii) Provision of the daily treatment was documented by two different nurses on different dates, both failed to transcribe the order into resident's electronic-treatment administration record (e-TAR). The first treatment was completed 18 days after the area of altered skin integrity was initially identified.

(iv) Staff acknowledged that the sample collection for diagnostic testing was not completed.

(v) The daily treatment for the other area of altered skin integrity was not transcribed into resident's e-TAR.

(vi) The physician referred the resident to an external clinic however the referral was not transcribed, and the resident was not referred until 22 days later.

(d) No action in response to signs of potential infection identified in assessments from five dates, from several areas of altered skin integrity.

(e) The resident's pain was not managed effectively during several incidents of reported pain by the home:

(i) The resident complained of pain to an identified area of altered skin integrity. The nurse acknowledged no pain assessment was completed and had endorsed to the incoming shift for follow-up. The physician was not contacted to obtain an order for as needed (PRN) pain medication, therefore no pain medication was administered to the resident.

(ii) Four days later, pain was noted to two areas of altered skin integrity, no pain assessment was completed, and there was no documentation that the resident's physician had been contacted.

(iii) Three weeks after the resident first reported pain, the RD documented that the resident complained of pain to a different site.

(iv) On the same date, the resident's substitute decision-maker (SDM) advised the home that the resident's pain was not being managed as the resident had pain while sitting. It was only after the SDM advised the home that the resident's pain medication was increased.

(v) Three subsequent days later, an order was written to increase the frequency of the resident's pain medication. Due to the lack of timeliness in processing the order the resident did not received their scheduled pain medication at the next prescribed time.

(f) No immediate action was taken for deteriorating skin integrity:

Two areas of altered skin integrity were assessed the NP as deteriorating. They wrote treatment orders three days later and explained that they did not have time to write orders sooner as they were trying to deal with other issues pertaining to the resident.

Failure of staff to provide the resident with timely areas of altered skin integrity identification and assessments, implementation of treatment orders for deteriorating areas of altered skin integrity, referrals, action in response to potential infection, and effective pain management demonstrates a pattern of inaction that jeopardized the resident's health.

Sources:
Review of the resident's clinical records, physician and NP orders, photos of altered skin integrity, interviews with RPN, NP and other staff.
[649]

This order must be complied with by November 8, 2022

COMPLIANCE ORDER CO#002 GENERAL REQUIREMENTS FOR PROGRAMS

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 34. (2)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Plan *FLTCA, 2021, s. 155 (1) (b)*

Specifically, the licensee shall prepare, submit and implement a plan to ensure interventions and residents' response to the interventions under the skin and wound care program are documented.

The plan must include but is not limited to, the following:
(a) A documentation process for rounds and assessment by the Skin Care Coordinator (SCC) in response to resident's altered skin integrity progress. Altered skin integrity rounds are to be completed by the SCC in person with the registered staff on the home unit.
(b) Development of procedures and education for all registered staff on the following:
(i) Completion of skin and wound assessments including required component of each assessment.
(ii) Safe and accurate use of electronic documentation systems, including expectations for users logging in and out of the system.
(iii) Safe and accurate documentation standards including the use of late entries.
A timeline is to be established for the implementation of each component of steps A through B within the compliance due date.

Please submit the written plan for achieving compliance for inspection 2022_1528_0002 to Julie Ann Hing, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by August 26, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

Non-compliance with: O. Reg. 246/22 s. 34. (2).

The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound care program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
The following documentation issues were identified.

(a) There was no documentation by the SCC who was responsible to assess residents with high-risk areas of altered skin integrity.
During identified periods there was no documentation by the SCC related to the progress of the resident's altered skin integrity. They reported that they had assessed the resident's altered skin integrity but did not have enough time to document.

(b) The resident's weekly skin and wound assessments were not completed in their entirety. Pertinent information such as evidence of odour, pain, infection, progress, and exudate and type of treatment were not routinely included in the weekly assessments.

(c) Documentation was completed by registered staff in the resident health records on several dates for various altered skin integrity sites when they did not work. The DOC was aware that if a registered staff did not log out of the point of care system another staff could log in and access their profile and document as them.

(d) Late entry documentation was made nine days later that an identified area of altered skin integrity was deteriorating.

Failure of staff to provide accurate documentation, altered skin integrity assessments and progress by the SCC, completion of weekly skin and wound assessments in their entirety places the resident at risk of not having issues identified and addressed timely with prompt action.

Sources:
Review of the resident's clinical records, interviews with RPNs, SCC, DOC and other staff. [649]

This order must be complied with by November 8, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order AMP#001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s. 34. (2)

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order #002

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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #001 of 2019_767643_0024, O. Reg. 79/10 , s. 30 (2)

This is the first time an AMP 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.*

COMPLIANCE ORDER CO#003 REQUIRED PROGRAMS

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22, s. 53. (1) 1.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order FLTCA 2021, s. 155 (1)

The Licensee has failed to comply with O. Reg. 246/22 s. 53. (1) 1

The licensee shall:

(a) Conduct random audits of the home's fall prevention and management program for residents identified as high risk for falls for four weeks following the service of this order. The audits must include these components of the falls program:
(i) Completion of post-fall assessments in Risk Incident Management (RIM) for each documented fall.
(ii) Completion of clinical monitoring assessments every shift for 24 hours to monitor potential complications post-fall.
(iii) Head injury routine (HIR) monitoring assessments are completed at the frequency prescribed in the home's policy.
(iv) Completion and documentation of interdisciplinary resident care review after a resident sustains three or more falls in one month.

(b) Maintain a written record of the audits, including the date, person conducting the audit, resident and staff audited, results of each audit, and actions taken in response to the audit findings.
(c) Retrain all registered staff (RN and RPN) on the above areas, including the definition of a fall.
(d) Maintain a record of the training provided, including the date, staff signed attendance, and who provided the training.

Grounds

Non-compliance with: O. Reg. 246/22 s. 53. (1) 1.

The licensee has failed to ensure that the interdisciplinary fall prevention and management program was implemented to reduce the incidence of falls and risk of injury for a resident.

Rationale and Summary
Several gaps were identified with the implementation of the home's fall prevention program when the resident fell.

The home's Fall Prevention Program last reviewed on May 7, 2021, and March 17, 2022, were not implemented by the staff as follows:
(a) A post-fall assessment was not completed in RIM when the resident fell.

(b) Assessments were not completed for the resident at the frequency of every shift for 24 hours after they fell.

(c) The HIR was not completed at the frequency required when the resident had unwitnessed falls.

(d) There was no documentation of an interdisciplinary resident care review involving the resident's substitute decision-maker (SDM) after three or more falls in one month.

Assistant Director of Care (ADOC) who was the home's falls lead indicated there were no interdisciplinary care review with the resident's SDM as the resident's falls were not true falls. Registered staff and the falls lead did not agree on what constituted a fall.

Failure to implement the falls prevention and management program for the resident, increased their risk of falls and injury.

Sources:
Review of the resident's clinical records, risk management, home's policy titled Falls Prevention Program last reviewed May 7, 2021, and March 17, 2022, interviews with Nurse Consultant (NC), ADOC, and other staff.
[649]

This order must be complied with by November 8, 2022

COMPLIANCE ORDER CO#004 REQUIRED PROGRAMS

NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22, s.55 (2) (b) (iv)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order FLTCA 2021, s. 155 (1)

The Licensee has failed to comply with O. Reg. 246/22 , s .55 (2) (b) (iv)

The licensee shall:

(a) Registered staff member to conduct weekly skin assessments for residents exhibiting alteration in skin integrity.
(b) Initiate separate orders for each treatment for altered skin integrity; and separate skin and wound assessments, so the completion of each is documented individually by the compliance due date.

Grounds

Non-compliance with: O. Reg. 246/22, s.55 (2) (b) (iv)

The licensee has failed to ensure that a resident who was exhibiting pressure ulcers was assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

The following gaps were identified with the resident's weekly skin and wound assessments.

Weekly skin and wound assessments were not consistently completed for multiple areas of altered skin integrity on several identified dates in a two-month period. During this time the areas of altered skin integrity deteriorated and/or increased in size.

In addition to the above areas of altered skin integrity, two unidentified areas of altered skin integrity noted in NC #004 were not assessed weekly by registered staff.

Failure to complete timely weekly skin and wound assessments for all areas of altered skin integrity resulted in staff not responding to deteriorating areas of altered skin integrity and timely treatment was missed.

Sources:

Review of the resident's clinical records, weekly skin and wound assessments, interviews with SCC, NP and other staff.
[649]

This order must be complied with by November 8, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order AMP#002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22, s.55 (2) (b) (iv)

Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order #004

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$5,500.00,** 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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #003 of 2019_767643_0024, O. Reg. 79/10, s. 50. (2) (b) (iv)

This is the first time an AMP 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.*

COMPLIANCE ORDER CO#005 PLAN OF CARE

NC#008 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

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

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (b) prepare, submit and implement a written plan for achieving compliance with a requirement under this Act.

Compliance Plan *FLTCA, 2021, s. 155 (1) (b)*

Specifically, the licensee shall prepare, submit and implement a plan to ensure collaboration between staff.

The plan must include but is not limited to, the following:

(a) Clearly defined roles for the interdisciplinary team in the skin and wound care program, in order to identify and take action upon signs and symptoms of altered skin integrity infection and deteriorating areas of altered skin integrity.
(b) A communication process for the interdisciplinary team to flag high risk areas of altered skin integrity for further assessment and treatment by the home's physician.
(c) A process for registered staff to refer residents with complex or deteriorating areas of altered skin integrity to the SCC and external resources for additional assessment and treatment.
(d) Refresher training for registered staff, on the home's physician order process to ensure timely processing of treatment and diagnostic orders.

Note: all components of the plan must be documented including who will be responsible for each area. A timeline is to be established for the implementation of each component of steps A through D within the compliance due date.

Please submit the written plan for achieving compliance for inspection 2022_1528_0002 to Julie Ann Hing, LTC Homes Inspector, MLTC, by email to TorontoSAO.moh@ontario.ca by August 26, 2022

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

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

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

Rationale and Summary

The following evidence demonstrated a lack of collaboration in the assessment of the resident.

(a) Staff did not collaborate with the physician when signs of potential infection were noted in assessments for areas of altered skin integrity. The DOC advised that for any altered skin integrity exhibiting odour, the physician should have been notified and a swab obtained. No swabs were obtained when odours were identified in the assessments of the resident.

(b) Lack of collaboration between the NP and physician for deteriorating areas of altered skin integrity:

(i) The NP documented that the resident had two deteriorating areas of altered skin integrity. They acknowledged that they had consulted with the physician the next day on another issue for the resident but had not collaborated with them on the two deteriorating areas of altered skin integrity, and no treatment was initiated as a result.

(c) Lack of collaboration between registered staff and NP for deteriorating areas of altered skin integrity:

(i) Registered staff documented that an identified area of altered skin integrity was deteriorating. They acknowledged that they had not communicated this change to the NP or the physician. The NP advised that they only became aware of the area of altered skin integrity during the provision of a different treatment.

(d) No collaboration on processing and transcription of physician's orders:

The physician identified signs of potential infection from a site and ordered diagnostic testing. The physician also ordered daily treatment to another area of altered skin integrity. The date

was not written when the first nurse transcribed the order, and the second nurse signed the order 12 days later.

(i) The first nurse signed that the above orders were transcribed. Upon review they realized that they had not transcribed the orders and stated that they assumed it had been done by another staff.

(ii) The second nurse signed that the above orders were transcribed 12 days later and that they had checked the orders even though they were not processed.

(e) There was no collaboration on the resident's reported pain:

(i) The resident complained of pain to an identified area of altered skin integrity. The nurse acknowledged no pain assessment was completed and the physician was not contacted to obtain an order for as needed (PRN) pain medication.

(ii) On another date pain was noted to two areas of altered skin integrity, no pain assessment was documented, and no action was taken in response to the resident's pain.

(iii) On another date, the resident's SDM advised the home that the resident's pain was not being managed as the resident had pain while sitting. It was only after the SDM advised the home that the resident's pain medication was increased. Pain assessments completed prior to this date did not indicate that the resident had pain related to multiple areas of altered skin integrity.

(f) No collaboration between registered staff to ensure timely processing and signing of physician's orders. Multiple orders were not signed by a second nurse and some orders were signed 10, 12, and 19 days later.

(g) Lack of collaboration between front-line staff and management for documented health concerns for the resident.

(i) On multiple dates there was documentation of signs of infection from areas of altered skin integrity. No actions were taken to obtain diagnostic testing for these areas.

(ii) The resident complained of pain to an identified area of altered skin integrity on two different dates. No orders for PRN pain medication were available for administration, until 20 days later.

(iii) During an identified period, there were 13 documentations of deteriorating areas of altered skin integrity before treatment orders were written.

The DOC and NC advised that they read residents' progress notes in preparation for morning report, but no actions were taken for the above documented concerns.

(h) There was no documented referral process to the SCC for the resident's altered skin integrity.

(i) The home's skin and wound policy directed the registered staff to notify the SCC by referral when a resident was exhibiting altered skin integrity. Several staff advised that this was not the current practice in the home.

Failure to collaborate upon identification of odours, deteriorating areas of altered skin integrity, processing of physician orders, pain, timely processing and signing of orders, indicated a lack of integration and consistency in the assessment of the resident.

Sources:
Review of the resident's clinical records, physician and NP orders, photos of altered skin integrity, interviews with RPN, NP and other staff.
[649]

This order must be complied with by November 8, 2022

This compliance order is also considered a written notification and is being referred to the Director for further action by the Director WN/DR#001

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.

- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.