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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2020	2020_715672_0006	006871-20, 007925-20, 008485-20, 009358-20, 010537-20	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER BATTEN (672), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 21, 22, 25-30, June 1-6, 8-13, 15-20 and 22-30, 2020

The following intakes were inspected during this Complaint inspection:

Five intakes related to screening and protocols for COVID-19, communication with the licensee, resident safety and residents' plans of care during the for COVID-19 outbreak and the nutrition and hydration practices in the home.

During the course of the inspection, the inspector(s) toured the home, reviewed health care records, observed residents and staff to resident interactions, reviewed employee training records, schedules and internal policies related to Emergency Codes, Prevention of Abuse and Neglect, Pain Management, Skin and Wound Care, Infusion Therapy, Internal Transfers and Nutrition Care and Hydration.

PLEASE NOTE: A Voluntary Plan of Compliance related to LTCHA, 2007, r. 8, (1) (b), identified in a concurrent inspection #2020_715672_0007 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Corporate Clinical Consultant, Director of Care (DOC), Associate Directors of Care (ADOC), Acting Director of Care (DOC), Acting Associate Director of Care (ADOC), Resident Relations Coordinators, Nurse Practitioner (NP), RAI Coordinator, Skin and Wound Care Champion (SWCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Services Manager (DSM) and dietary aides (DA), Registered Dietician (RD), Physiotherapists (PT) and physiotherapy assistants (PTAs), Director of Programs (DP) and recreational aides (RA), Office Manager (OM), Nursing/Scheduling Clerks, Environmental Services Manager (ESM) and environmental/housekeeping support staff (ESS/HSS), Physicians (MD), receptionists, Military clinical staff, Military support staff, Public Health Inspectors, Managers from the Centenary Health Services Hospital, family members, and residents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- 7 WN(s)
- 6 VPC(s)
- 1 CO(s)
- 0 DR(s)
- 0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

This IP was initiated related to a complaint alleging resident #001 was unwell and not offered adequate hydration. The resident passed away in the hospital.

A review of the resident's fluid intake identified two different methods of reporting a resident’s 'total by day' fluid intake. The differing entries did not provide a clear representation of the resident’s actual fluid intake for evaluation. A review of progress notes failed to identify any evaluation of the resident’s fluid intake.

Upon further review, the report documented resident #001’s intake on different dates which represented a change and was less than the resident’s usual intake.

A review of the progress notes identified that resident #001 refused to eat at lunch and supper on identified dates and specified interventions were implemented.

On an identified date, the on-call physician #159 documented an assessment that included the resident was 'eating prepared meals and hydrating ok'. Their plan included for staff to 'promote fluids'. An interview with the physician revealed the physician had not assessed the resident on site and had spoken with a nurse who reported the resident was eating and drinking well. The reason for the plan to 'promote fluids' was related to the resident's condition, which could affect intake and the resident's fever.

The physician interview revealed they were unaware that the resident’s intake had changed and was reduced. The physician stated had they known, they definitely would have taken it into consideration when creating the resident’s treatment plan, as there were definitely things that could have been done to assist with hydration in the home.

Inspector #672 reviewed the staffing schedule for the identified date the on-call physician was contacted and interviewed staff but was unable to identify the nurse who had spoken with the physician.

After separate interviews with full time and part time RPN’s and RN’s, #114, #193, #136, #169, #152, #236 and #158, it was apparent the home did not have a program in place to evaluate a resident’s fluid intake as monitored by PSWs. Reportedly, a program had not been in place “for years”.

On a specified date, the POA initiated resident #001’s transfer to the hospital and received a diagnosis. The resident passed away in hospital.

An interview with the DOC revealed that it was an expectation in the home that registered staff were evaluating a resident’s fluid intake and taking the appropriate actions, which included referring to the registered dietitian. The DOC confirmed there was not a system in place to evaluate the fluid intake of residents, including resident #001, and that staff inaccurately reported the resident’s intake to the physician.

The licensee does not have a fluid monitoring and evaluation system in place. Staff are unaware of how to document and report concerns. There is unclear entries in the fluid monitoring records, inaccurate reporting of intake to the physician and no system to evaluate the fluid intake of resident #001 with risks to their hydration. [s. 68. (2) (d)]

2. The licensee has failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The Ministry of Long-Term Care received a complaint alleging that resident #003, who required toileting assistance, was not being toileted when requested, as a result of reduced staffing and subsequently began to self restrict their fluid intake to avoid urinating in a brief. The resident was transferred to the hospital and treated for an identified condition, then discharged to another facility.

A record review identified the resident was not cognitively impaired and a telephone interview was conducted with resident #003. The resident shared that they began to restrict the amount of fluids they drank due to worrying about not receiving the required assistance to go to the washroom.

A progress note from an identified date indicated Resident Relations Coordinator (RRC), #142 had spoken with the resident's family and discussed their concerns regarding the resident’s fluid intake and toileting. An interview with RRC #142 revealed the family wanted to confirm staff were providing the resident with water at meals and shared the resident's intake was not as good as their norm.

A further record review identified NP #149 assessed the resident related to staff reporting the resident's condition. The plan included staff were to encourage fluid intake for the resident.

A review of resident #003's fluid intake identified ‘0’ intake over three specified days, as the resident's intake had not been monitored.

After separate interviews with full time and part time RPN’s and RN’s, #114, #193, #136, #169, #152, #236 and #158 staff revealed the home did not have a program in place to evaluate a resident’s fluid intake. Staff reported the program had not been in place for several years.

An interview with the DOC revealed that it was an expectation that registered staff were evaluating a resident’s fluid intake and taking the appropriate actions including referring to the registered dietitian when required. The DOC confirmed there was currently no system in place in the home to evaluate the fluid intake of residents, including resident #003.

On an identified date, the resident was transferred to the hospital upon their family’s request and was admitted for a specified diagnosis. A review of the ‘Discharge Summary’ identified the resident was transferred to the hospital with identified symptoms, had not

been eating and drinking well and had been admitted to the hospital with a specified diagnosis. [s. 68. (2) (d)]

3. Related to an area of non-compliance identified in r. 68. (2) (d) related to residents #001 and #003, the sample size was expanded to include resident #015.

A record review of resident #015's current plan of care identified the resident at high nutrition risk due to specified reasons.

During an identified period, resident #015's fluid intake report identified a change in the resident's intake of less than assessed.

A record review of the progress notes during an identified period failed to identify any evaluation of the resident's change and decline in their fluid intake.

After separate interviews with full time and part time RPN's and RN's, #114, #193, #136, #169, #152, #236 and #158 it was apparent the home did not have a program in place to evaluate a resident's fluid intake. Staff reported the program had not been in place for several years.

In separate interviews with the Director of Food Services and RD, they confirmed that they do not receive nursing referrals related to a resident's poor or changed fluid intake, nor for residents who have presented with signs and symptoms of dehydration. The RD confirmed that a system to evaluate a resident's fluid intake was not in place.

During an interview, the DOC indicated that it was an expectation in the home for registered staff to evaluate a resident's fluid intake and take appropriate actions as required, such as referring to the RD. The DOC confirmed there was no system in place to evaluate the fluid intake of residents, which would have identified the resident's fluid intake was not being monitored. [s. 68. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #001 presented with a risk to their hydration due to their health conditions. On a specified date, the physician documented for staff to closely monitor the resident and promote fluids.

A record review of resident #001’s fluid intake failed to identify an increased intake in resident #001’s fluid consumption.

During separate interviews, PSWs #117, #120, #121 and #174 indicated to Inspector #672 that resident #001 had become ill, would often complain of thirst and had a water jug kept at the bedside, which staff tried to keep full. The PSW staff further indicated that due to staffing concerns, it was difficult to ensure “small tasks like that were being done when we were just trying to make sure everyone was clean and fed”.

An interview with the DOC while jointly reviewing the resident’s health record with Inspector #110 led the DOC to confirm there was no plan of care set out related to the physician’s plan to ‘promote fluids’. The DOC again confirmed that the home did not have a policy for "push fluids", and there were no directions on a plan of care for the staff to follow.

On a specified date, the resident was transferred to hospital and received an identified diagnosis. The resident passed away in the hospital. [s. 6. (1) (a)]

2. Related to an area of non-compliance identified in s. 6. (1) (a) related to resident #001, the sample size was expanded to include residents #003 and #076.

The Ministry of Long-Term Care received a complaint alleging that resident #003 was self restricting their fluid intake to avoid urinating in a brief.

A record review identified Nurse Practitioner (NP) #149 assessed the resident as a result of staff reporting the resident's condition. The NP's plan included staff to encourage fluid intake for resident #003.

A review of resident #003's fluid intake report revealed there was no monitoring of the resident's intake on two identified days.

An interview with the DOC while jointly reviewing the resident's health record with Inspector #110 led the DOC to confirm there was no plan of care set out related to the NP's documentation requesting staff to encourage the resident's fluid intake.

The resident was transferred to the hospital and treated for an identified diagnosis. [s. 6. (1) (a)]

3. Related to an area of non-compliance identified in s. 6. (1) (a) related to resident #001, the sample size was expanded to include residents #003 and #076.

Resident #076 had a risk identified to their hydration and NP #234 ordered staff to 'encourage fluid intake to prevent dehydration'.

A record review identified a RD assessment that failed to assess the resident's hydration status and set out the planned care related to the order for staff to encourage fluid intake for resident #076.

An interview with the RD confirmed they had not assessed the resident's hydration status as required and there was no planned care to 'encourage fluid intake to prevent dehydration'.

An interview with the DOC confirmed that nursing staff had not set out the planned care for resident #076's order and that the home did not have a policy for when a resident received an order/direction for staff to "push fluids". [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care for each resident sets out the planned care for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 68 (1) (b) The nutrition care and hydration program is a required organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

According to LTCHA, 2007. O. Reg. 79/10, r. 71 (5) The licensee was to ensure an individualized menu was developed for the resident if their needs cannot be met through the home’s menu cycle.

During record review, Inspector #672 reviewed an internal policy related to Clear Fluid Diets, which indicated a clear fluid menu for residents who required clear fluids on a

short-term basis was to be available at all times for residents.

A complaint was received by the Director from resident #001's family member, which indicated the resident was very ill, and they were worried the resident was not being taken care of properly in the LTCH. The complaint further indicated the resident was not receiving the food and/or fluids they required, especially while ill, and felt the resident should have been offered specific food items including a supplement.

During a telephone interview with resident #001’s family member/complainant, they indicated that while resident #001 was in the home and ill, the resident would often complain to the family member that they were unable to keep food down and were not receiving a clear fluid diet, despite asking staff over several days. The complainant further indicated they also had contacted the home over several days and requested resident #001 receive a clear fluid diet, but the resident continued to report they were not receiving that intervention. The complainant indicated resident #001 also complained they were often thirsty, as it would take extended periods of time for staff members to respond to the call bell when they would request a drink therefore the complainant would call into the home to attempt to get a staff member to bring resident #001 a drink. Lastly, the complainant they had requested resident #001 be transferred to hospital several times, due to the resident’s declining condition, but the resident had not been transferred therefore on an identified date, they contacted emergency services on their own and initiated the transfer of resident #001 to the local hospital. Resident #001 was admitted to the hospital, where they passed away.

During record review, Inspector #672 observed that over multiple days, resident #001 was documented to have ingested less than half of their required fluid intake. Inspector #672 noted that resident #001 was transferred to hospital on an identified date, and passed away. Inspector #672 reviewed resident #001’s hospital notes which indicated the resident was admitted to hospital with an identified diagnoses. During review of resident #001’s progress notes, Inspector #672 observed notes which indicated resident #001 ate poorly and/or refused their meal(s) due to multiple complaints and requested clear fluids in place of the regular diet being served.

During review of resident #001’s weights during a specified period of time, Inspector #672 noted that during that period, resident #001 had lost weight.

During separate interviews, PSWs #117, #120, #121 and #174 indicated that resident #001 had become ill and often complained they could not tolerate the food being served.

PSWs #117, #120, #121 and #174 further indicated that a clear fluid diet was an intervention which had been offered to residents in the home in the past but did not believe it was an intervention available during the COVID-19 outbreak when residents became ill. PSWs #117, #120, #121 and #174 verified that resident #001 was not offered and did not receive a clear fluid diet during a specified period of time.

During record review, Inspector #672 noted that on a specified date, the LTCH was declared by Public Health to be in a COVID-19 outbreak. During the outbreak, all but seven of the residents in the home were infected with the illness, 53 residents passed away as a result of the illness and another eight residents passed away during that time related to other illnesses.

During separate interviews with Inspectors #110 and #672, RPNs #114, #125, #130, #136, #152 and #212 indicated they were aware of the internal clear fluid diet policy but were not aware of it being implemented for any resident during the COVID-19 outbreak when residents became ill.

During separate interviews with Inspector #110, the Registered Dietician (RD) and Food Services Manager (FSM) indicated the expectation in the home was for all nutrition and hydration policies to be complied with. The RD and FSM further indicated that specific to the clear fluid diet policy should have been offered and/or served to resident(s) if a resident met the indicators for use as outlined in the policy. According to the RD and FSM, they did not recall receiving any referrals requesting a clear fluid diet for resident #001, or any other resident, during the COVID-19 outbreak. The FSM indicated they did not recall seeing clear fluid diets being prepared/served through the kitchen, or an increase in the usage of clear fluid diet supplies, such as Ginger-Ale or Jello.

During separate interviews with Inspectors #110 and #672, the DOC and the Corporate Clinical Consultant indicated the expectation in the home was for all internal policies to be complied with at all times, which included the Clear Fluid Diet policy during the COVID-19 outbreak. The DOC indicated to Inspector #110 they believed that offering residents a clear fluid diet “was not on anyone’s radar” due to what was occurring in the home during that time, regarding the COVID-19 outbreak and related staffing crisis.

The licensee failed to ensure that the internal policy related to Clear Fluid Diets was complied with, related to resident #001 and other ill residents in the home.
[s. 8. (1) (a),s. 8. (1) (b)]

2. According to LTCHA, 2007. O. Reg. 79/10, r. 68 (1) (b) The nutrition care and hydration program is a required organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

During record review, Inspector #672 reviewed the internal policy related to infusion therapy, which indicated residents receiving infusion therapy, including hypodermoclysis, were to be monitored and staff were to change the subcutaneous catheter at specified intervals and any other time a problem was noted with the site.

A Critical Incident Report was submitted to the Director related to an alleged incident of improper/incompetent treatment of resident #023, which resulted in harm to the resident. The CIR indicated that on an identified date, RPN #167 found resident #023 in bed in a specified condition due to the action of an RPN. This caused resident #023 to experience identified negative side effects. RPN #167 immediately responded and contacted the physician.

During separate interviews, RPNs #167 and #145 indicated that on the identified date, the resident was received in bed and observed to be in distress and an identified area was noted to be abnormal.

During an interview, RPN #195 indicated they were responsible for resident #023 during an identified shift, when they noted the resident’s treatment was not working. RPN #195 did not act according to the home's policy when the treatment was not being administered as it should have been. RPN #195 indicated they did not verbally pass this information along to the oncoming shift because they did not feel it was important, as the last time they had assessed resident #023 they had not observed any negative outcomes to the resident.

During separate interviews, Acting DOC #100, Acting ADOC #134, Corporate Clinical Consultant and DOC #150 indicated the expectation in the home was that the staff must follow the process according to the policy. The Corporate Clinical Consultant further indicated the outcome of the internal investigation into the incident with resident #023 was that RPN #195 had not followed the internal policies related to the identified therapy, and they were receiving education and mentoring from DOC #150 in an attempt to ensure further incidents did not occur and all internal policies and procedures were adhered to.

The licensee failed to ensure that the internal policy related to the treatment was adhered

to, related to resident #023's identified treatment, which resulted in a negative outcome to the resident. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition along with assessing the resident's hydration status, and any risks related to hydration.

This IP was initiated related to a complaint alleging resident #001 was unwell and not offered adequate hydration leading to the resident's deterioration and transfer to hospital. The resident passed away in the hospital.

A record review identified that resident #001's hydration needs were assessed.

During separate interviews, PSWs #117, #120, #121 and #174 indicated to Inspector #672 that resident #001 had become ill, would often complain of thirst and had a water jug kept at the bedside, which staff tried to keep full. The PSW staff further indicated that due to staffing concerns, it was difficult to ensure “small tasks like that were being done when we were just trying to make sure everyone was clean and fed”.

During record review, documentation identified resident #001’s family prompted an assessment be completed by the Registered Dietitian (RD) related to a request for a nutritional supplement. The documentation included the resident was not consuming the assessed amount of fluid.

The home's Nutrition/Hydration Risk Identification Tool identified a resident is at High Hydration Risk when they consume less than 50% of the recommended daily fluid intake and/or signs and symptoms of dehydration are noted.

On an identified date, resident #001's fluid intake would have placed the resident at high hydration risk as it was half of their recommended daily fluid intake.

An interview with the RD confirmed they failed to assess the resident's hydration status and risks to hydration by way of reduced intake and having specified health conditions.

On an identified date, the SDM initiated resident #001’s transfer to the hospital and the resident received identified diagnoses. The hospital admission assessment completed by physician #233 identified that on examination the patient appeared dehydrated. The resident passed away in hospital.

The RD failed to assess the resident’s hydration status and their risks to hydration. [s. 26. (4) (a),s. 26. (4) (b)]

2. Related to an area of non -compliance identified in r. 26. (4) (b) related to resident #001, the sample size was expanded to include resident #097.

A record review of resident #097's health record identified a hydration assessment at the time of the resident's admission to the LTCH.

During record review, a progress note written by the RD stated the resident consumed greater than half per day. An assessment was not documented on the resident's fluid consumption.

A record review of the fluid intake documentation for an identified period stated the resident seldom consumed the assessed amount per day.

A record review of the resident’s health care record indicated that during an identified period, the resident's fluid intake was reported as low. On an identified date, NP #149 documented that staff were to continue to monitor the resident and encourage intake of fluids to prevent dehydration.

On an identified date, the RD documented an assessment that indicated the resident 'drinks fair'. The documentation failed to identify a hydration assessment or plan of care to identify the risks to the resident's hydration.

On an identified date, the resident was identified with an identified diagnosis and on a later identified date, was placed on a specified treatment for fluid rehydration.

During an interview, RD #217 acknowledged the lack of a hydration assessment when the resident's fluid intake was reported as greater than 1500ml per day, and again when the resident's fluid intake was determined to be 'fair'. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the registered dietitian completes a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition along with assessing the resident's hydration status, and any risks related to hydration, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

The Ministry of Long-Term Care received a complaint alleging that resident #003, who required toileting assistance, was not being toileted as needed, as a result of reduced staffing. As a result, the resident subsequently began to self restrict their fluid intake to avoid urinating in a brief. The resident was transferred to the hospital and treated for an identified diagnosis and then discharged to another facility.

A record review identified the resident was not cognitively impaired and a telephone interview was conducted with resident #003. The resident shared that they began to restrict the amount of fluids they drank due to worrying about not receiving the required assistance to go to the washroom and confirmed there were times when they needed to go to the bathroom and were not assisted by staff. The resident identified a two week period of time prior to being transferred to the hospital, when they were not being toileted when needed. The resident stated that they were toileted once per day in the morning and did not have a choice other than voiding in their brief throughout the remainder of the day. The resident further indicated there were days when they were not toileted at all.

A review of the hospital patient triage record and discharge summary identified that the resident was exhibiting identified symptoms, were not drinking or urinating and had been admitted to hospital due to an identified diagnosis.

The resident’s health record identified the resident as usually continent, used the toilet, was aware of their urge to void and required an identified number of staff to transfer on and off the toilet.

A review of specified documentation was completed, which identified that resident #003

was 'continent' or 'both continent and incontinent' with voiding on the toilet. Later documentation indicated the resident was 'incontinent' with no voiding on the toilet. The resident interview confirmed they remained continent, were unassisted to the toilet regularly or on request and had no choice other than to void in their brief, which supported the documentation of incontinent with no voiding on the toilet.

An interview with full time PSW #235 described the resident as cognitively very aware and required the assistance of an identified number of staff to the washroom in the morning, before lunch and that the resident would ask to use the toilet. The staff indicated it was not very often that the resident was incontinent.

During an interview, PSW #127 indicated resident #003 required assistance with toileting and would attempt to transfer independently. When resident #003 was found to be attempting to self transfer, staff would assist them.

An interview with the evening shift RPN #145 identified that they transferred the resident to the hospital on a specified date. The RPN shared that the unit was often short staffed specific to PSWs on the evening shift with times when just one PSW would be on duty, instead of the planned three and there had been a lot of agency staff leading up to the resident's transfer to hospital. The RPN stated they recalled that on one shift when they provided the resident's medications around 1430hrs, the resident asked to use the washroom, which they reported to a PSW. RPN #145 indicated that when they returned to the resident at approximately 1730hrs to administer medications, the resident informed them that no one had come to take them to the washroom so the RPN assisted and the resident voided on the toilet.

An interview with NP #149 who assessed the resident related to staff reporting the resident was febrile, stated that during their assessment the resident asked to use the washroom revealing the resident remained aware to request toileting assistance.

A review of the staffing schedule identified PSW shortages on the day and evening shifts consistently during a specified period of time. The schedule indicated there were day and evening shifts covered by one PSW instead of three, who provided care to 19 to 21 of the residents on the home area, which was half of the home's planned staffing, especially during an identified time period.

The licensee failed to ensure that resident #003, who was unable to toilet independently some or all of the time, received assistance from staff to manage and maintain

continence. [s. 51. (2) (c)]

2. Related to an area of non-compliance identified in r. 51. (2) (c) related to resident #003, the sample size was expanded to include resident #050.

A record review of the resident's written plan of care identified the resident was able to use the toilet, had a rehab toileting schedule and required an identified number of staff members to assist with transfers to the toilet during the day and evening shifts.

PSWs #135 and #116 approached Inspector #110 to ask if residents who required transferring with a specified lift were to be toileted as in the case of resident #050. The staff stated the resident has been asking to use the toilet for bowel continence. The PSWs both stated the resident currently voided in their brief and was not toileted despite the resident’s request to go on the toilet. PSW #135 shared the resident had not been toileted for over a year.

A record review identified the resident's cognitive performance scale indicated mild impairment. During an interview, the resident shared with Inspector #110 that they wanted to have bowel movements on the toilet, as it was hard to move their bowels while lying down in bed. The resident stated they had a bowel movement in their brief, while in bed, earlier that day.

An interview with the resident's evening shift PSW #225, shared that the resident had rang the call bell for toileting assistance at the start of their shift and that along with another PSW, they assisted the resident from their wheelchair to their bed and turned the resident onto their side so that they could void in their brief. The PSW continued saying that after the resident had a bowel movement, the resident would ring the call bell again and staff would assist with cleaning and changing of their brief. The PSW indicated they were unsure of why the resident was not taken to the toilet, stating this was the practice other staff had directed them to follow since they started working in the home.

The licensee failed to ensure that a resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.
[s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident who are unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu was developed for a resident if their needs could not be met through the home's menu cycle.

This IP was initiated related to a family member's complaint that the resident was not provided three meals per day and was complaining of being hungry.

A record review identified that the registered dietitian had awareness that the resident had a chronic low intake at meals, with an average of 25-50% being consumed. Nursing staff referred to the RD twice during an identified period of time, related to resident #028 consuming 'less than 50% of meal in the last three days'. Interventions were implemented, but the resident's weight continued to decline.

A further record review identified a nursing referral to the RD on a later identified date, stating the resident had a change in appetite, intake was consistently less than 50% for three days and the resident was continuously complaining about the taste of the food and their poor appetite.

An interview with full time PSW #116 and PSW #205 confirmed that resident #028 was a poor eater and would often only consume the soup and not eat anything else.

During an interview, RPN #136 stated that the resident was of a specified heritage and did not like the taste of the food in the home but would eat the soup. The staff stated the resident would probably eat identified foods which were more culturally specific for the resident.

A review of the internal policy related to individualized and selected menus identified that the Registered Dietitian was expected to plan and provide individualized menus for residents whose needs could not be met through the care community's menu cycle.

During an interview with resident #028, by way of translator PTA #102, the resident stated their first food preference would be identified cultural foods. The resident confirmed that since their admission to the home, they had not been asked if they would like to be offered culturally specific foods.

An interview with the Director of Food Services confirmed culturally specific foods were not considered for resident #028 and that they had cultural foods they could try at lunch the next day.

A follow-up interview with PTA #102 revealed they had spoken to the resident and confirmed resident #028 had received culturally specific foods for lunch and had liked it. The PTA confirmed to Inspector they saw the resident eating the food.

An interview with the RD confirmed that resident #028’s needs were not being met through the regular menu cycle and an individualized menu had not been considered.
[s. 71. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an individualized menu is developed for a resident if their needs cannot be met through the home’s menu cycle, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets, special needs and preferences.

On a specified date, the home was placed on isolation precaution, with dining room service suspended and tray service initiated to all residents. Resident #003 continued on tray service until they were transferred to the hospital and admitted for treatment of an identified diagnosis.

During an identified period of time prior to resident #003 being discharged to the hospital, the resident received tray service. The food delivery system was described as plates of food wrapped with saran and the diet texture written on top. Staff would refer to a list attached to the cart to identify the resident's name, room number, diet, diet texture and fluid consistency. Nursing staff were responsible for providing the fluids to each resident, however the list provided failed to identify residents' special needs or preferences, especially important for those unwell or nonverbal.

A record review identified an assessment note by nurse practitioner #149 which stated the resident was febrile and for staff to encourage fluid intake.

The resident's initial assessment by the RD identified resident #003's fluid preferences to include identified likes and dislikes.

During separate interviews, PSW #127 indicated resident #003 loved an identified drink and did not like another identified drink. PSW #235 indicated the resident liked a different identified drink, and PSW #108 stated the resident loved identified drinks and did not enjoy another identified drink.

An interview with agency PSW #232 shared there had been no process in place to guide agency staff in offering residents their preferred fluids.

The licensee failed to ensure that all staff assisting residents were aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes a process to ensure that all staff assisting residents are aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

Issued on this 30th day of July, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER BATTEN (672), DIANE BROWN (110)
Inspection No. / No de l'inspection :	2020_715672_0006
Log No. / No de registre :	006871-20, 007925-20, 008485-20, 009358-20, 010537-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jane Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee must be compliant with r. 68 of the LTCHA.

Specifically, the licensee must:

1) Develop and implement a system which includes a process for staff to implement when an order/recommendation is received to 'push fluids'. A documented record must be kept.

2) Educate the PSW and Registered staff members on the process to follow when an order/recommendation is received to 'push fluids'. A documented record must be kept.

3) Conduct weekly audits on the fluid monitoring process to ensure PSW's are following directions and the registered staff are implementing recommendations. A documented record must be kept.

4) Continue auditing and documenting the results until no further concerns arise with the staff implementing recommendations.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

This IP was initiated related to a complaint alleging resident #001 was unwell and not offered adequate hydration. The resident passed away in the hospital.

A review of the resident's fluid intake identified two different methods of reporting a resident's 'total by day' fluid intake. The differing entries did not provide a clear representation of the resident's actual fluid intake for evaluation. A review of progress notes failed to identify any evaluation of the resident's fluid intake.

Upon further review, the report documented resident #001's intake on different dates which represented a change and was less than the resident's usual intake.

A review of the progress notes identified that resident #001 refused to eat at

lunch and supper on identified dates and specified interventions were implemented.

On an identified date, the on-call physician #159 documented an assessment that included the resident was 'eating prepared meals and hydrating ok'. Their plan included for staff to 'promote fluids'. An interview with the physician revealed the physician had not assessed the resident on site and had spoken with a nurse who reported the resident was eating and drinking well. The reason for the plan to 'promote fluids' was related to the resident's condition, which could affect intake and the resident's fever.

The physician interview revealed they were unaware that the resident’s intake had changed and was reduced. The physician stated had they known, they definitely would have taken it into consideration when creating the resident’s treatment plan, as there were definitely things that could have been done to assist with hydration in the home.

Inspector #672 reviewed the staffing schedule for the identified date the on-call physician was contacted and interviewed staff but was unable to identify the nurse who had spoken with the physician.

After separate interviews with full time and part time RPN’s and RN’s, #114, #193, #136, #169, #152, #236 and #158, it was apparent the home did not have a program in place to evaluate a resident’s fluid intake as monitored by PSWs. Reportedly, a program had not been in place “for years”.

On a specified date, the POA initiated resident #001’s transfer to the hospital and received a diagnosis. The resident passed away in hospital.

An interview with the DOC revealed that it was an expectation in the home that registered staff were evaluating a resident’s fluid intake and taking the appropriate actions, which included referring to the registered dietitian. The DOC confirmed there was not a system in place to evaluate the fluid intake of residents, including resident #001, and that staff inaccurately reported the resident’s intake to the physician.

The licensee does not have a fluid monitoring and evaluation system in place.

Staff are unaware of how to document and report concerns. There is unclear entries in the fluid monitoring records, inaccurate reporting of intake to the physician and no system to evaluate the fluid intake of resident #001 with risks to their hydration.
(110)

2. The licensee has failed to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The Ministry of Long-Term Care received a complaint alleging that resident #003, who required toileting assistance, was not being toileted when requested, as a result of reduced staffing and subsequently began to self restrict their fluid intake to avoid urinating in a brief. The resident was transferred to the hospital and treated for an identified condition, then discharged to another facility.

A record review identified the resident was not cognitively impaired and a telephone interview was conducted with resident #003. The resident shared that they began to restrict the amount of fluids they drank due to worrying about not receiving the required assistance to go to the washroom.

A progress note from an identified date indicated Resident Relations Coordinator (RRC), #142 had spoken with the resident's family and discussed their concerns regarding the resident's fluid intake and toileting. An interview with RRC #142 revealed the family wanted to confirm staff were providing the resident with water at meals and shared the resident's intake was not as good as their norm.

A further record review identified NP #149 assessed the resident related to staff reporting the resident's condition. The plan included staff were to encourage fluid intake for the resident.

A review of resident #003's fluid intake identified '0' intake over three specified days, as the resident's intake had not been monitored.

After separate interviews with full time and part time RPN's and RN's, #114, #193, #136, #169, #152, #236 and #158 staff revealed the home did not have a program in place to evaluate a resident's fluid intake. Staff reported the program

had not been in place for several years.

An interview with the DOC revealed that it was an expectation that registered staff were evaluating a resident’s fluid intake and taking the appropriate actions including referring to the registered dietitian when required. The DOC confirmed there was currently no system in place in the home to evaluate the fluid intake of residents, including resident #003.

On an identified date, the resident was transferred to the hospital upon their family’s request and was admitted for a specified diagnosis. A review of the ‘Discharge Summary’ identified the resident was transferred to the hospital with identified symptoms, had not been eating and drinking well and had been admitted to the hospital with a specified diagnosis. (110)

3. Related to an area of non-compliance identified in r. 68. (2) (d) related to residents #001 and #003, the sample size was expanded to include resident #015.

A record review of resident #015's current plan of care identified the resident at high nutrition risk due to specified reasons.

During an identified period, resident #015's fluid intake report identified a change in the resident's intake of less than assessed.

A record review of the progress notes during an identified period failed to identify any evaluation of the resident's change and decline in their fluid intake.

After separate interviews with full time and part time RPN’s and RN’s, #114, #193, #136, #169, #152, #236 and #158 it was apparent the home did not have a program in place to evaluate a resident’s fluid intake. Staff reported the program had not been in place for several years.

In separate interviews with the Director of Food Services and RD, they confirmed that they do not receive nursing referrals related to a resident's poor or changed fluid intake, nor for residents who have presented with signs and symptoms of dehydration. The RD confirmed that a system to evaluate a resident's fluid intake was not in place.

During an interview, the DOC indicated that it was an expectation in the home for registered staff to evaluate a resident's fluid intake and take appropriate actions as required, such as referring to the RD. The DOC confirmed there was no system in place to evaluate the fluid intake of residents, which would have identified the resident's fluid intake was not being monitored.

The severity of this non-compliance is determined to be actual harm as the residents suffered worsening conditions as a result of the fluid intake not being monitored. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Jennifer Batten

Service Area Office / Bureau régional de services : Central East Service Area Office